STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 3/28/16 through 3/31/16. Also reviewed in the course of this survey was complaint intake WY000002013. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Set ADON: Assistant Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157	F157 483.10(b)(11) - Notify of Changes (Injury, Decline/Room, Etc) Corrective Measures For Identified Residents: Resident #28's doctor was notified on 3/28/2016 Resident #23's doctor was notified on 3/13/2016 Using QA SBAR forms and care path algorithms the nurses will be directed when to notify a physician. Nurses will be inserviced on what constitutes a change of condition using the Interact change of condition - when to report to MD guideline. Identification of Others Potentially Affected by the Same Deficiency: All residents have the potential to be effected.	5/14/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admin | (X6) DATE: 5/12/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy and procedure review, and staff and resident interview, the facility failed to ensure the physician was notified of a change in condition in a timely manner for 2 of 12 sample residents (#23, #28). The findings were: 1. Interview with resident #28 on 3/29/16 at 8:50 AM revealed s/he was sick and not feeling well. The resident stated the nurse was aware and s/he had been seen by the physician. Review of a nursing fax notification to the physician showed on 3/28/16 the physician was notified the resident had been sick with a runny nose and cough since "Thursday last week [3/24/16]" The note further showed the resident's lungs were full of rhonchi (coarse rattling respiratory sounds) and crackles (clicking, rattling, or crackling sounds of the lungs). Review of a 3/26/16 nurse's note timed at 5 AM showed the resident was given Tylenol, a	F 157	Systemic Changes: With any symptom of illness, injury or decline residents will be assessed using the QA SBAR forms which have different care path algorithms that show the necessary steps to take when a change of condition is observed. . The SBAR process helps the nurse to gather all information needed to report to the physician and the care path criteria specifically tells them when to notify the physician. . Nursing staff will be in-serviced on the new procedures and policy. . A mandatory inservice will be given to all current nurses by 5-14-16 and this will be accomplished in small groups or individually. Education will include using the SBAR and care path forms, what constitutes a change of condition, and when to report to the physician. . Monitoring: Director of Nursing/designee will ensure compliance daily by monitoring charts and reviewing the 24 Hr. reports. On weekends the supervisory nurse will be called. Director of Nursing/designee will report to the QAPI committee monthly for review. Frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	

5/12/16

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F 157	Continued From page 2 decongestant, and cough syrup from physician standing orders. The note showed the "resident's temp [temperature] has decreased from 101.8 to 100 to 99..." Review of the 3/28/16 nursing note timed at 10 AM showed the physician's practitioner saw the resident and wrote orders for Zithromax (an anti-biotic medication) and prednisone (steroid medication). 2. Review of nurse's notes dated 3/11/16 and timed at 2 AM showed resident #23 had "been confused" and oxygen saturation had dropped to 83%. Review of nurse's notes dated 3/13/16 and timed at 2 AM showed the resident was confused, was not following directions, had expiratory wheezes, left lower lobe rales (an abnormal rattling sound heard through a stethoscope), edema to bilateral lower extremities, had an irregular heartbeat, had a temperature of 100.9, and oxygen saturation of 87%. Further, the note showed the physician was notified of the resident's change in condition, and new orders were received. Review of nurse's notes dated 3/15/16 and timed at 4:20 PM showed the resident was sent to the emergency room for evaluation and treatment related to symptoms. 3. Interview with the interim DON on 3/31/16 at 8:55 AM verified notification to the physician was expected when the change in condition was first identified regardless of the weekend. 4. Review of the policy titled "Guidelines for Notifying Physicians of Clinical Problems" revised February 2014 showed "...Immediate Notification (Acute) Problems...4. The following signs:...g. sudden onset of new confusion, paranoia and delusions, and/or physical aggression, or severe worsening of existing condition. h. Tachypnea	F 157		

Admin 5/12/16

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F 157	Continued From page 3 [rapid breathing] and dyspnea [difficult or labored breathing] with a pulse oximetry [oxygen saturation] below 90%..."	F 157		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure adequate hydration status for 1 of 6 sample residents (#40) who were at high risk for dehydration. The findings were: Review of the 2/19/16 quarterly MDS assessment showed resident #40 had some cognitive impairment with a BIMS score of 10. However, the resident was able to make him/herself understood and usually understood others. The resident required extensive assistance with physical assistance of at least one staff for all ADLs including eating. Review of the care plan related to skin integrity and risk of dehydration with a goal date of 5/24/16 showed approaches which included offering honey-thickened liquids each time care is provided in the resident's room or with snacks. Review of the nutrition care plan with a goal date of 5/24/16 showed the resident was to have honey-thickened liquids to be served with a spoon. Review of the registered dietitian note for 2/10/16 showed the resident weighed 212 pounds (96 killigrams) and typically consumed 240- 480 milliliters (mL) of fluids with	F 327	F327 483.25(j) - Sufficient Fluid to Maintain Hydration . Corrective Measures for Identified Residents: Thickened liquids were available to resident #40 in a bedside ice chest. The two CNAs cited were re-educated on 4/21/2016 with regards to offering fluids with all care. The recommended daily fluid amount was recalculated on 4/21/2016 for resident #40 by a certified dietary manager/certified food protection professional. . Thickened fluids are available at all times at bedside, in the nourishment room and the kitchen. All staff will be inserviced about providing residents with fluids when cares are provided in CNA meetings on 4/26/16 and 4/27/2016. All staff not able to attend will be met with in small groups or individually by 5/14/2016. . Identification of Others: All residents have the potential to be affected. . Systemic Changes: New fluid monitoring forms have been created to give to nurses, CNAs, NSAs, activities, and RAs to record fluids given at times other than meal times. These forms will be gathered at end of day by CNAs, added together and added to meal amounts and that total is given to the charge nurse. Night charge nurse adds to calculate 24 hour total. Total intake forms will be kept with the MAR for daily reminders. All nursing staff will be educated on this by 5/14/2016. Any new resident who requires the use of thickened liquids has their recommended daily fluid levels calculated by a certified dietary manager/certified food protection professional. .	5/14/2016

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F 327	Continued From page 4 meals. There was not an assessment available to show what the resident's fluid needs were estimated to be. The following concerns were identified: a. Observation on 3/29/16 at 9:55 AM showed resident #40 was transferred from a wheelchair to the bed with a mechanical lift by CNA #1 and CNA #2. The resident had a suprapubic catheter with dark amber to brow- colored urine draining into the catheter bag. Further, there were no liquids observed at the bedside, and the resident was not offered fluids during the observation. b. Interview with the resident on 3/29/16 at 10:50 AM revealed his/her mouth was "very dry" and at that time the resident's lips and mouth appeared to be dry with cracked lips and dried debris at the corners of the mouth. c. Review of the March 2016 meal intake information showed fluid intake during snacks were not recorded for any day. Further, the total fluid intake from meals on 3/27/16 was 640 mL, on 3/28/16 the resident consumed 420 mL for the day, 820 mL of fluids were recorded for the day on 3/29/16, and 720 mL for the day on 3/30/16. d. Review of the intake and output record showed there was limited information available for March 2016. The days with information recorded included 3/12, 3/13, 3/16, 3/17, and 3/27/16. On 3/27/16 the intake was shown as 240 mL intake. e. Interview with the DON on 3/31/16 at 8:55 AM verified the staff were expected to offer fluids during cares. Further, she stated the fluids provided with snacks were expected to be recorded. f. According to CD-HCF Dietetic Practice Group, Niedert K, Dorner B. Nutrition Care of the Older Adult. 2nd ed. Chicago, IL: American Dietetic Association; 2005. "Normal fluid needs	F 327	All residents have fluids at bedside to be offered during cares, at all meals, at snack times, and there are fluid stations on all units. Staff inserviced during previously mentioned inservice dates about offering fluids through out their shifts. . Monitoring: Director of Nursing/designee will review 24 Hr. fluid intake forms daily to ensure documentation is in place. The QAPI committee will review documentation and audits. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	

DSD 5/12/16

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F 327	Continued From page 5 are 25-30 mL of fluid/kg of actual body weight (ABW)." Based on the resident's weight in kg (96) the resident's estimated fluid needs for a day would be 2400-2880 mL.	F 327		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sanitary conditions were met in 1 of 1 kitchens. The findings were: 1. Observation on 3/30/16 at 11:45 AM showed dietary aide #1 handled the walk-in refrigerator door with her bare hands. Without performing hand hygiene the aide then put on gloves and proceeded to work cutting fruit. At 11:50 AM dietary aide #2 handled the door to a refrigerator unit with gloved hands and without disposing of the gloves the aide handled ready-to-eat fruit and clean dishes. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After	F 371	F371 483.35 Food Procure, Store/Prepare/Serve - Sanitary . Corrective Measures: In-services on 4/6/2016 with Registered Dietitian covered proper hand-washing and glove use. Any one not able to attend the in-service will be given 1-on-1 instruction. . The blenders were cleaned on 3/31/2016. . The ice machine cited has been cleaned and sanitized. A maintenance inspection was conducted. It was found that the debris cited was rust and hard water deposits. Based on that inspection, maintenance staff has determined that the ice machine cannot be restored to meet food code. It has been removed from service and will be physically removed from the kitchen no later than 5/14/2016. . The ceiling vents were cleaned on 4/15/16. . Staff has been re-educated on proper cleaning procedures for the kitchen area and equipment. . Identification of Others Potentially Affected by the Same Deficiency: All residents may potentially be affected. . Systemic Changes: The monthly cleaning roster will be updated to include cleaning the ceiling vents monthly or more frequently if needed.	5/14/2016

5/12/16

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F 371	Continued From page 6 handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands." 2. Observation on 3/28/16 at 4:45 PM showed there were 4 ceiling vents that were located above food preparation areas which had visible build-up of dust. In addition, the ice machine/dispenser located near the handwashing sink was in need of cleaning and sanitizing. There was a build up of green/brown-colored moist debris around the outside edge of the equipment, and the vent on the side of the machine had an accumulation of dust. There were also 2 food blenders which were in need of cleaning. There was dried food debris on the operation panel of these blenders and in the crevices of the equipment. The condition of these items remained the same when observed on 3/30/16 at 11:35 AM. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Interview with the certified dietary manager on 3/31/16 at 8:35 AM verified the equipment and vents were in need of cleaning. The manager was unaware of when the ice dispenser was last cleaned and planned to put in a maintenance request. She further verified handwashing/hand hygiene was expected to be done any time hands were soiled.	F 371	Monitoring: Handwashing and glove use audits will be completed by the Dietary Manager/designee every week. The Dietary Manager/designee will perform visual audits to ensure cleanliness of kitchen and equipment. Dietary Manager/designee will review cleaning rosters daily to ensure compliance. The QAPI committee will review documentation and audits. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	

5/12/16

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F 387 F 387 SS=D	Continued From page 7 483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure frequency of physician visits were completed as required for 1 of 13 sample residents (#18). The findings were: Review of the physician notes for resident #18 showed a physician had completed the 60-day review on 9/22/15. A physician assistant (PA) completed the following 60-day review on 11/3/15. The 11/3/15 note showed the resident had diagnoses that included uterine prolapse and dementia. Further, the resident was diagnosed with vaginitis with symptoms to include itching and rash around the genital area that extended down the legs. The medications Diflucan (antifungal) and anti-itch cream were prescribed. The note also showed 3 rotating antibiotics used for preventing UTIs (urinary tract infections) were temporarily discontinued. Review of the PA note dated 11/23/15 showed the resident's symptoms had not improved, the reddened area around the genitalia and legs had worsened, and there was increased skin breakdown between the thighs. Review of the 12/7/15 note showed the resident	F 387 F 387	F387 483.40 (c)(1)-(2) Frequency & Timeliness Of Physician Visit . Corrective Action of Identified Residents: Resident #18 was seen by the physician on 2/16/16 for a 60-day visit. The PA saw resident #18 on 2/22/16 and on 4/19/16. The resident is scheduled to see the physician on 6/16/16. . Health Information Manager reviewed Federal Regulation 483.40 and will provide a copy to each physician and Medical Director. . The Health Information Manager or designee will audit all resident health records for 60-day practitioner visitation schedule for each resident. . Identification of Others: All residents have a potential to be affected. . Systemic Changes: The Health Information Manager or designee will revise the monthly practitioner visitation schedule to ensure compliance with routine and timely physician visits. . Monitoring: Health Information Manager or designee will monitor practitioner progress notes and visitation schedule. The QAPI committee will review documentation and audits. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	5/14/2016

5/12/16

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F 387	Continued From page 8 had developed diarrhea after starting the antibiotic Rocephin for treatment of a UTI. Continued review showed the resident was not seen by a physician until 2/16/16, 105 days later and 147 days after the previous physician 60-day review. Interview with the DON on 3/31/16 at 9:25 AM, confirmed there was no documentation of additional physician visits.	F 387		
F 407 SS=D	483.45(b) REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician was notified of residents' lack of progress and eventual discharge for 2 of 4 sample residents (#5, #12) receiving specialized rehabilitation. The findings were: 1. Review of the 12/22/15 physician order showed a request for a physical therapist to evaluate and treat resident #5 for low back pain and sciatica (pain extending from the lower back to the lower extremity). The 12/23/15 physician order showed the therapist was to evaluate and treat for pain using a variety of modalities to include exercise, peripheral nerve stimulation and manual therapy. The physical therapy (PT) evaluation and treatment plan showed the evaluation was completed on 12/23/15. Further, it showed the resident had right hip surgery and right hip, knee and ankle pain with weakness. The plan of care	F 407	Corrective Action of Identified Residents: Resident #5 has new PT orders as of 4/19/2016. Physician was notified of discontinued therapy services for resident #12 on 4/22/16. . Identification of Others Potentially Affected by the Same Deficiency: All residents may potentially be affected. . Systemic Changes: Therapy aides will document discussions with therapists when therapy is not progressing as expected. Therapists will notify physicians when considering discontinuation of therapy services and will document their communication with physicians. Residents receiving therapy services will be reviewed at weekly Medicare meetings. A representative from Gottsche Rehabilitative Services who is able to report on status updates for each resident receiving therapy participates in the Medicare meetings. Information obtained from Medicare meetings will be utilized to audit resident charts. . Monitoring: MDS Coordinator or designee will ensure audits are conducted utilizing information from Medicare meetings. Resident charts will be audited for supporting documentation of therapy staff and physician communication and resident treatment status. The QAPI committee will review documentation and audits. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	5/14/2016

5/12/16

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F 407	Continued From page 9 included exercises, manual therapy and other modalities that were not specified. Review of the PT exercise flow sheet dated 12/29/15 showed the physical therapy assistant (PTA) completed range of motion exercises and supine to sit and sit to stand therapeutic activities. The 12/31/15 flow sheet showed the resident refused therapy. On 1/4/16, the PTA noted therapeutic procedures were provided and gait training. During subsequent visits, on 1/12/16, 1/14/16 and 1/19/16, the PTA noted the resident complained of right hip pain and pain radiating to the lower extremity. There was no documentation to show the physical therapist and physician were notified of the refusals and complaints of pain. Review of the 1/20/16 physician order showed therapy was discontinued due to non-compliance. 2. Review of the "Re-Certification Plan of Care" for PT dated 8/12/15 for resident #12 showed problems included poor posture and decreased balance. Review of the PT exercise flow sheet dated 8/18/15 through 9/1/15 showed the PTA documented the resident refused therapy. In addition, a PTA note dated 8/28/15 showed the resident had refused therapy without reason and the aide would consult with the supervising therapist. There was no further documentation to show the therapist was consulted. The flow sheet dated 9/2/15 showed the resident was discontinued from therapy due to non-compliance. There was no further documentation to indicate there was discussion with the therapist and the physician was notified. 3. Interview with the physical therapy office scheduler on 3/31/16 at 10:25 AM, verified there was no further documentation to show the therapist was consulted concerning the residents'	F 407		

DND 5/12/16

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F 407	Continued From page 10 refusals, or that the physician was notified. Interview with the DON on 3/31/16 at 9:15 AM, acknowledged the therapist and physician needed to be consulted.	F 407		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	Corrective Action of Identified Residents: The facility corrected this issue by contacting the State Dept. of Epidemiology Coordinator, Amy Spieker (307-777-8687) on 4/22/16. . Infection Control Nurse or designee will review Federal Regulations 483.65 on Infection Control and review the current Infection Control Program with the Facility Administrator and DON. . To identify other residents potentially affected, the DON will audit all vital sign charting and nursing notes since evidence of infection presented itself on March 11, 2016. Any residents with documented signs and symptoms of infection such as elevated temperature, cough, decreased oxygen saturation, nasal drainage, diminished lung sounds, and chest congestion will be included in an infection control report for the incident. . Staff will be educated at an in-service by May 14, 2016. During that in-service all staff will be updated to changes in facility's infection control policies that include identifying and tracking measures. . Hooks have been purchased to address the issue with the catheter bags in reference to resident #40. These hooks have been placed on the hoyer and bath lift to provide a place to hang catheter bags preventing them from being placed improperly. . CNA #1 and #2 were re-educated on 4/21/16. All CNA staff will be trained in proper catheter bag placement. . Identification of Others Potentially Affected by the Same Deficiency: All residents are potentially affected in regards to infection control. All residents with a catheter are potentially affected. .	5/14/2016

5/12/16

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	535021	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 441	Continued From page 11 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, review of infection control documentation, and policy and procedure review, the facility failed to effectively implement measures to prevent the spread of a known respiratory infection for 9 of 9 sample residents (#1, #5, #12, #15, #23, #26, #28, #36, #40) with respiratory illness symptoms. Further, the facility failed to ensure staff followed infection prevention practices for 1 of 3 sample residents (#40) with urinary catheters. The findings were: 1. Interview with resident #28 on 3/29/16 at 8:50 AM revealed s/he was sick and not feeling well. The resident stated the nurse was aware and s/he had been seen by the physician. Interview with RN #1 on 3/29/16 at 10:55 AM verified resident #28 had been sick for several days and was being treated with antibiotics. The nurse revealed several residents had similar upper respiratory symptoms. Interview with RN #1 on 3/29/16 at 2:45 PM revealed in the case of infection, the facility had standing orders which were available. These included orders for cough syrup, phenylphrine (a vasoconstrictor and decongestant), and Tylenol which the facility could administer while monitoring vital signs (including temperature), behavior changes, lung sounds, and mucous color before the physician was notified. The following concerns were identified:	F 441	Systemic Changes: Process of informing the Infection Control Nurse of issues will be reformed. An in-service will be held for all RN's regarding routine documentation, reporting requirements, and agency responsibility to report. To prevent future problems with reporting, the infection control nurse will track all residents with suspected or confirmed infections. Any trend noted will be reported to the Medical Director, County Health Officer (if needed), individual families, resident's PCP, and appropriate state agencies as necessary. . Monitoring: Documentation will be put into place to identify infections and ensure infections are being reported properly. . DON or designee will perform visual spot check audits on the proper placement of catheters bags. . The QAPI committee will review documentation and audits. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	

5/12/16

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F 441	Continued From page 12 a. Interview with the infection control nurse on 3/29/16 at 3:15 revealed she was only aware of 2 residents with respiratory symptoms and she did not have a list of residents that were being treated for respiratory symptoms. b. Review of the medical records for resident's #1, #5, #12, #15, #23, #26, #28, #36, and #40 showed the onset of symptoms began on 3/11/16 and continued through 3/29/16. Symptoms of the illness included cough, elevated temperature, decreased oxygen saturation, nasal drainage, diminished lung sounds, and chest congestion. c. Review of the infection control program showed there was no evidence of monitoring for March 2016. d. Interview with the infection control nurse on 3/30/16 at 3:45 PM revealed the respiratory illness was an outbreak and the facility had not implemented any interventions to prevent the spread of the illness. Further, the facility had not reported the outbreak to epidemiology and the infection control nurse had been working on the floor and no time had been dedicated to infection prevention. The infection control nurse was not aware if the medical director was aware of the respiratory illness outbreak. 2. Observation on 3/29/16 at 9:55 AM showed resident # 40 was transferred from the bed to the bathroom with a mechanical lift by CNA #1 and CNA #2. The resident had a suprapubic catheter with dark amber to brown-colored urine draining into the catheter bag. The urine collection bag was hung on the lift at the level of the bladder with a dependent loop hanging below the bag. The resident was left in the bathroom from 10 AM to 10:23 AM. Continued observation showed at 10:23 AM, the urine in the tube had backed up	F 441		

DD 5/12/16

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F 441	Continued From page 13 toward the resident and not into the collection bag. An interview with the infection control nurse on 3/30/16 at 3:45 PM, confirmed the urine collection bag needed to be placed below the bladder without a dependent loop to allow urine to flow away from the resident. 3. Review of the policy titled "Catheter Care, Urinary" revised 9/14, showed for "Maintaining Unobstructed Urine Flow... 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of Medicare requirements for signatures, the facility failed to ensure physician notes were complete for 1 of 13 sample residents	F 514	Corrective Action of Identified Residents: The physician note for resident #18 that was not signed was pulled from the resident chart and put into the physician's folder for physician to sign at his next visit. . Identification of Others Potentially Affected by the Same Deficiency: All residents are potentially affected. . Systemic Changes: Health Information Manager or designee will transcribe physician's progress note and email it to physician for signature. A copy of the progress note will be printed and placed in the respective resident's chart so the information will be readily accessible to the staff. When the signed copy has been returned, the Health Information Manager or designee will replace the unsigned copy in the chart with the signed progress note.	5/14/2016

5/12/16

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F 514	Continued From page 14 (#18). The findings were: Review of the physician progress notes for resident #18 showed the following concerns: a. Review of the physician note dated 7/28/15 showed the resident was seen for a 60-day evaluation. An assessment was completed and medications reviewed. The note was dictated and available in the medical record. Further review showed the physician did not review and sign the note until 9/22/15, 56 days later. b. Review of the physician note dated 9/22/15 showed the resident was seen for a 60-day evaluation. The note was dictated and available in the medical record. Further review showed the physician did not review and sign the note until 2/16/15, 147 days later. c. Interview with the DON on 3/31/16 at 9:20 AM acknowledged the physician notes were not signed timely. d. According to "Medicare Program Integrity Manual Chapter 3-Verifying Potential Errors and Taking Corrective Actions" last revised on 12/4/15 showed: 3.3.2.4-Signature Requirements "For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature..."	F 514	Current policy states that the transcriptions must be returned to the facility within 10 days of the visit. . Monitoring: Monthly audits will ensure physician signatures have been obtained. . The Health Information Manager or designee is responsible for doing and monitoring the monthly audits. . The QAPI committee will review documentation and audits. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520	Corrective Action: QAA/QAPI committee reviewed Federal Regulations 483.75 Quality Assessment and Assurance. . Attendance sheets were obtained showing physician did attend all meetings. . Identification of Others Potentially Affected by the Same Deficiency: All residents are potentially affected. . Systemic Changes: QAA will meet monthly. A physician will be in attendance at quarterly meetings.	5/14/2016

DAD 5/12/16

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F 520	Continued From page 15 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of survey history, and review of quality assurance meeting attendance, the facility failed to implement an effective quality assurance performance improvement (QAPI) program to identify and correct previously-identified infection control deficiencies. In addition, the required committee members were not in attendance for the QAPI meetings from January 2015 to February 2016. The findings were: Review of the 2012, 2013, 2014, and 2015 previous recertification surveys showed cited deficiencies included F441 (infection control program and practices). Although the citation was put back into compliance on 3/15/15, the deficient practice is being cited again during this 3/31/16 survey. In addition, review of the meeting attendance showed the committee lacked	F 520	The members of this committee monitor all deficiencies identified in the 2016 CMS-2567. In addition to the monitoring of deficiencies identified by the State, the committee will identify quality deficiencies through procedures developed by the committee. All identified deficiencies will result in the development of an action plan by the committee. The action plan will take into consideration the most appropriate form of corrective action needed. All action plans will be implemented by the committee. Department managers will be involved in implementing any departmental changes necessary to comply with the action plan and any procedural changes. The committee will evaluate action plans for effectiveness. If an action plan is determined by the committee as ineffective the committee will revise the action plan utilizing methods to ensure improvement in the deficient practice. Attendance and meeting minutes will be documented. Identified deficiencies, action plans, and results will be documented. . Monitoring: Meeting minutes and attendance sheets will be documented for every QAA/QAPI meeting. . Administrator or designee will review documentation and monitor effectiveness of committee.	

5/12/16

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F 520	Continued From page 16 physician involvement for all meetings except April 2015 and February 2016. Interview with the interim administrator on 3/31/16 at 10:15 AM verified she and the management team needed to further develop the QAPI program to ensure effective interventions to sustain compliance.	F 520		

5/12/16