DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 6/20/16 through 6/23/16. Complaints reviewed in the course of this survey were complaint intakes WY000002059, WY000002088, WY000002090, and WY000002217. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure residents were assessed for safe medication self-administration for 1 of 14 sample residents (#50) and 3 non-sample residents (#51, #61, #71). The findings were: 1. Observation of the area surrounding the bed	F 176	The facility will ensure that individual residents may self-administer drugs only if the interdisciplinary team (IDT) has determined that this practice is safe. 1. Resident #61 will be re-assessed for safety of self-administration of drugs. If this assessment and the IDT review concludes that this practice is unsafe for this resident, the eye drops will be removed from the resident's bedside and self-administration of drugs will not be permitted.	8/7/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Kaiser, NHA | TITLE: Administrator | (X6) DATE: 7/18/2016

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.

Received
WY Dept of Health
JUL 18 2016
Healthcare Licensing and Surveys

POC accepted with agreed on changes.
Spoke with Jeanne Kaiser 7/22/16, 1:55 PM.
SOOD, state surveyor

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F 176	Continued From page 1 of resident #61 on 6/20/16 between 6:05 PM and 6:40 PM showed a bottle of eye drops at the bedside. The resident was not in the room. Medical record review showed a physician order for the following eyedrops: 1. Timolol 0.5% 1 drop each eye at bedtime, and 2. Cyclosporine 0.05% 1 drop each eye bid (twice a day). Each order stated the drops could be kept at the bedside. The following concerns were identified: a. Review of the medical record for the resident showed the facility failed to determine the resident was capable of safely self-administering medications. b. Review of a 5/11/16 nursing assessment showed the resident could not manage medication administration independently, and required a nurse to administer the medications. 2. Observation of the area surrounding the bed of resident #71 on 6/20/16 between 6:05 PM and 6:40 PM revealed two separate doses of white powder in 30 cc administration cups each. The powder appeared consistent with Miralax (laxative). The resident was not in the room. Medical record reviewed showed a physician order for Miralax. The following concerns were identified: a. Review of the medical record for the resident showed the facility failed to determine the resident was capable of safely self-administering medications. b. Review of a 4/16/16 nursing assessment showed the resident required nursing assistance for medication administration. 3. Observation of the area surrounding the bed of resident #51 on 6/20/16 between 6:05 PM and 6:40 PM revealed a medication cup which contained 2 white pills and 1 brown pill. The	F 176	2. Resident #71 will be re-assessed for safety of self-administration of drugs. If this assessment and the IDT review concludes that this practice is unsafe for this resident, self-administration of drugs will not be permitted. 3. Resident #51 will be re-assessed for safety of self-administration of drugs. If this assessment and the IDT review concludes that this practice is unsafe for this resident, self-administration of drugs will not be permitted. 4. Resident #50 will be re-assessed for safety of self-administration of drugs. If this assessment and the IDT review concludes that this practice is unsafe for this resident, self-administration of drugs will not be permitted. 5. Nursing staff will be educated through a series of staff meeting /inservices regarding the location of the assessment for safety of self-administration of drugs in the medical record, and the requirement that medications are not to be left at the bedside unless the resident has been assessed as safe for this practice. 6. The policy titled "Medication Administration by Nursing Personnel" will be reviewed and revised as appropriate.	

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F 176	Continued From page 2 resident was not in the room. Review of the medical record showed resident #51 was not assessed as being able to self-administer medications. 4. Observation during a medication pass on 6/21/16 at 8:15 AM showed LPN #1 delivered medications (pills) to resident #50. The nurse left the medications with the resident and did not stay with the resident to verify the medications were taken. The following concerns were identified: a. Review of the medical record for the resident showed the facility failed to determine the resident was capable of safely self-administering medications. b. Review of an 8/26/16 admission nursing assessment showed the resident required assistance with medication, and prior to admission the resident had managed his/her medications poorly. 5. Interview with the DON on 6/23/16 at 8:10 AM revealed her expectation was for medications to be administered to residents unless an assessment determined the resident was capable of self-administering medications. She also confirmed medications were not to be left open at the bedside. 6. Review of the policy titled "Medication administration by Nursing Personnel" last revised 08/04 showed "...No medication will be left at the patient's bedside except for the following: nitroglycerin SL tabs which will be limited to 10, respiratory inhalers, patient-controlled analgesia, antacids, throat lozenges and external preps for topical application....The nurse administering the medication will stay with the patient until the medication is taken..."	F 176	7. The Director of Nursing (DON) will conduct observations of at least three medication passes per week and provide any necessary on-the-spot staff education if deficient practices are observed, until resolved. The results of these observations will be reported to the facility's Performance Improvement/Quality Improvement (PI/QI) Committee on a quarterly basis until compliance reaches 100% for three consecutive quarters, with periodic observations on an ongoing basis to ensure sustained compliance. 8. The Director of Nursing (DON) will monitor.	

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	The facility will continue to ensure that all alleged violations involving mistreatment, neglect, abuse, or misappropriation of resident property are thoroughly investigated, and will prevent any further potential abuse while the investigation is in progress. 1. Certified Nursing Assistant (CNA) #2 is no longer employed, as her last day of work at the facility was 6/9/2016. 2. Resident #47 was discharged from the facility on 6/30/2016 and now resides in a hospice facility. 3. Investigations of any future allegations of mistreatment, neglect, abuse, or misappropriation of resident property will include interviews of additional residents and staff members beyond those who may have personal knowledge of the allegation. 4. The facility's Abuse policy will be revised to clarify the practices used to prevent any further potential abuse while the investigation of an allegation is in progress.	8/7/2016

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SA 7/22/16

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview, review of facility incidents and investigations, and facility policies and procedures, the facility failed to ensure resident safety during abuse investigations for 1 of 4 incidents reviewed (involving resident #47). The findings were: Review of an incident dated 12/9/15 showed CNA #1 reported to the charge nurse that CNA #2 was seen yelling at resident #47 to go to the bathroom. Review of the investigation showed the facility interviewed the CNA who witnessed the event, the charge nurse, and CNA #2 regarding the incident. The investigation also showed CNA #2's employment application, references, and background checks were included. There was no documented evidence of interviews with other employees or residents. There was no documentation to show how the facility ensured resident safety during the investigation. Interview with the administrator, DON, and social service director on 6/22/16 at 11:30 AM revealed the incident occurred in the secure dementia unit, and CNA #2 rarely worked in that unit. They further confirmed no additional residents who resided in other units in which the CNA worked were interviewed, stating, "If resident interviews were done, they would be in the packet [of investigation documentation]." The administrator stated the CNA was removed from working in the secure unit during the investigation, but verified the CNA continued working in other areas of the facility. Further, the interview revealed the policy to ensure resident safety during investigations of abuse was to place the accused staff member on paid leave, and this was done in "99% of cases"	F 225	5. All staff members potentially involved in the investigation of allegations of abuse will be provided education on the policy, specific to interview of additional residents and staff members, and how to ensure resident protection during the investigation. 6. All allegations and investigations of reports of mistreatment, neglect, abuse, or misappropriation of resident property will be reported to the facility's PI/QI Committee on a quarterly basis by the Administrator. 7. The Administrator will monitor and ensure compliance. 8. See also, Plan of Correction for F226.	

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F 225	Continued From page 5 unless they were qualified to work in other areas of the facility, such as the office. Review of the facility's policy and procedure titled "Abuse- Identification, Prevention, Reporting of Crime Against a Resident," revised 7/11/11, showed: "9. Protection: During investigation or any reports of alleged violations, any employee/s involved shall be assigned to a non-patient care area if available, and if not available, or if the allegation is of a very serious nature, the employee will be placed on paid leave until the investigation is completed."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility policies and procedures, the facility failed to develop policies to ensure all allegations of abuse were reported immediately to the facility administrator and to the State survey and certification agency. The findings were: Review of the facility policy titled "Abuse-Identification, Prevention and Reporting of Crime Against a Resident," revised 7/11/11, showed: "...10. Reporting: Any individual providing services to the facility who has any reasonable suspicion of a crime being committed against an	F 226	The facility will ensure that a policy clearly defines that all allegations of abuse are reported to the facility administrator and to the State survey and certification agency. 1. The facility's policy on Abuse Identification, Prevention and Reporting will be revised to specifically reflect the current practice of reporting all allegations of mistreatment, neglect, and abuse of residents and misappropriation of resident property to the State survey and certification agency and others as required. 2. All staff will be re-educated on the revised abuse policy specific to reporting requirements.	8/7/2016

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F 226	Continued From page 6 individual who is a resident of or is receiving care from the facility is obligated to report the information to the state survey agency and at least one local law enforcement entity..." The policy failed to ensure all alleged violations were reported to the State survey agency as required. Interview with the administrator, DON, and social service director on 6/22/16 at 11:30 AM confirmed the policy was not specific in stating all alleged violations needed to be reported.	F 226	3. All allegations, reporting, and investigation of mistreatment, neglect, abuse, or misappropriation of resident property will be reported to the facility's PI/QI Committee on a quarterly basis by the Administrator. 4. The Administrator will monitor and ensure compliance.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to provide care in a manner that maintained resident dignity during 1 of 6 meal observations (affecting resident #32). The findings were: 1. Review of the 5/3/16 quarterly MDS assessment showed resident #32 had diagnoses that included depression and hemiplegia. Additionally, the resident's cognitive abilities were assessed to be moderately impaired for daily decision making. Further review showed s/he required set up assistance and supervision with eating. Review of the 4/28/16 care plan showed the resident had diagnoses that included dementia, hydrocephalous, and a history of	F 241	The facility will continue to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. Resident #32 will be monitored on a daily basis at mealtimes by the charge nurse, and at least three times per week by the DON, Registered Dietitian, or Staff Development Coordinator (SDC) to ensure proper positioning and adequate assistance with the meal is provided.	8/7/2016

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F 241	Continued From page 7 transient ischemic attacks. Review of the ADL care plan showed the resident required "Set up for eating and drinking, assist as necessary." The following concerns were noted: Observation on 6/23/16 at 9:33 AM showed resident #32 sitting at a table in the milieu with a plate of scrambled eggs and a pancake cut into bite-sized pieces. Further observation showed the resident leaning to the right in the wheelchair, and attempting to pick up some scrambled eggs with his/her fingers. Interview with the resident at that time revealed s/he needed help with the meal, stating "I can't feed myself and I'm hungry." The resident further stated s/he had been "waiting here a while." Two aides and a nurse were observed in the milieu at this time. The surveyor approached CNA #3 to request assistance. The CNA was then observed to reposition the resident upright in the wheelchair and then kneel down to assist the resident with the meal. Interview with CNA #3 on 6/23/16 at 9:37 AM revealed the resident had been in the dining room, but needed to go back to his/her room to use the toilet. She added the breakfast tray was brought to the milieu for the resident to eat there. She further stated the resident had been sitting at the table with the food for approximately 30 minutes. Observation on 6/23/16 at 9:47 AM showed CNA #3 assisted the resident with the meal, of which approximately 70% of the meal had been eaten. Interview with the DON on 6/23/16 at 12:05 PM verified staff "should not have left [the resident] sitting at the table" without ensuring proper positioning or checking if s/he required	F 241	2. The staff will be further educated by the Administrator and Director of Nursing regarding care practices to maintain or enhance each resident's dignity and respect. 3. The DON, Registered Dietitian, or Staff Development Coordinator will observe at least five meals per week throughout all dining areas to ensure all residents' positioning and assistance with dining promotes their dignity and respect. 4. The results of these observations will be reported to the facility's PI/QI Committee on a quarterly basis until 100% compliance is achieved for three consecutive quarters, and then periodically to ensure sustained compliance. 5. The DON will monitor.	

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F 241	Continued From page 8 assistance with the meal.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident, family, and staff interview, policy and procedure review, review of the activity participation log, and activity calendar review the facility failed to ensure activities were performed to ensure psychosocial well-being for 4 of 4 sample residents (#35, #36, #41, #45) in the secure unit and 2 of 10 sample residents (#56, #75) outside the secure unit. The findings were: 1. Review of the annual MDS assessment dated 5/12/16 showed resident #45 was severely cognitively impaired. Further, review showed the activity assessment was not completed with the resident or family; however, the staff portion was completed. Review of the activity participation for the resident from 6/1/16 to 6/20/16 showed the facility documented that 2 activities were offered per day at 9 AM and 3 PM. Review of the activities care plan showed the resident had interventions that included: Invite and encourage attending an activity, assist with transporting, assist during activities as needed, keep actively involved during activity, and daily social visits. The following concerns were identified:	F 248	The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 1. A new, comprehensive Activity assessment will be conducted on Residents #35, #36, #41, #45, and #56, (Resident #75 died on 6/28/2016) including interview of each interviewable resident, and interviews of any available family members/responsible parties of those residents who are not interviewable. From these assessments, an individualized activities plan will be developed and provided to the residents, and this activity plan will be reflected on the residents' comprehensive plan of care. Activity participation will be documented daily and summarized in the residents' medical record at least quarterly.	8/7/2016

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F 248	Continued From page 9 a. Observation on 6/21/16 from 9:50 AM to 1:37 PM showed there were no activities performed with or for the residents residing in the secure unit. The television was on and music was playing in the background while the resident was in the dining area. b. Review of activity participation on 6/21/16 1:38 PM showed resident #45 participated in 30 minutes of music. c. Review of the 9 AM activity participation log for June 2016 showed the scheduled activities were "Reminisce" on Monday, "Manicures" on Tuesday, "Crafts" on Wednesday, "Games" on Thursday, "Hand Massage" on Friday, "Exercises" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. d. Review of the 3 PM activity participation log for June 2016 showed the scheduled activities were "Games" on Monday, "Crafts" on Tuesday, "Manicures" on Wednesday, "Reminisce Group" on Thursday, "Cookie Social" on Friday, "Movie" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. e. Review of the 9 AM activity participation record showed the resident participated in "music" 7 out of 20 days. The resident participated in activities titled "patio" and "visit with Dawn" on 2 out of 20 days. No activities were documented 11 out of 20 days. f. Review of the 3 PM activity participation record showed the resident participated in "ice cream social" and "socializing" 4 out of 20 days. The resident participated in activities titled "dancing" 1 out 20 days and "one on one" 1 out of 20 days. No activities were documented 14 out of 20 days. g. Further review of the medical record	F 248	2. All residents' activity assessments conducted upon admission will include interview of the resident when appropriate, and interview of the family/responsible parties if the resident is not interviewable. 3. All activity assessments will be reviewed ~~on a quarterly basis and upon any significant change in condition~~, and revised as appropriate to accommodate current abilities and interests. Activity participation will be documented daily and summarized in the residents' medical record at least quarterly. 4. Additional staff members outside of the Activities Department will be trained to drive the facility bus for residents' transportation to significantly reduce the incidence of cancellation of scheduled activities.	

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	535027	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 248	Continued From page 10 showed no evidence any assessment was completed with the resident or family to ensure an individualized activity program was provided. 2. Review of the quarterly MDS assessment dated 6/3/16 showed resident #35 was severely cognitively impaired. Review of the annual MDS assessment dated 12/7/15 showed the activity assessment was not completed with the resident or family; however, the staff portion was completed. Review of activity participation for the resident from 6/1/16 to 6/20/16 showed the facility documented that 2 activities were offered per day at 9 AM and 3 PM. Review of the activities care plan showed the resident had interventions that included: invite to all activities, sit with and give assistance during an activity, daily social visits, enjoys sitting by the birds and going for walks, [family] visits often, and offer picture books/coloring sheets at the table. The following concerns were identified: a. Review of the 9 AM activity participation log for June 2016 showed the scheduled activities were "Reminisce" on Monday, "Manicures" on Tuesday, "Crafts" on Wednesday, "Games" on Thursday, "Hand Massage" on Friday, "Exercises" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. b. Review of the 3 PM activity participation log for June 2016 showed the scheduled activities were "Games" on Monday, "Crafts" on Tuesday, "Manicures" on Wednesday, "Reminisce Group" on Thursday, "Cookie Social" on Friday, "Movie" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. c. Review of the 9 AM activity participation record showed the resident participated in an	F 248	5. Additional activities will be added to the weekend activities calendar through re-alignment of activities staff hours, addition of volunteers, contract services, and/or addition of staff hours to the activities program. 6. The proper completion of activities assessments, provision of activities in accordance with those assessments, documentation of residents' activities participation, and number of scheduled activities that are cancelled will be monitored by the Administrator, and reported quarterly to the facility's PI/QI Committee. 7. The Administrator will monitor.	

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F 248	Continued From page 11 activity titled "music" 12 out of 20 days. The resident participated in activities titled "reading group", "family visits", and "coloring" 3 out 20 days. No activities were documented 5 out of 20 days. d. Review of the 3 PM activity participation record showed the resident participated in activities titled "socializing", "patio", or "family visits" for 18 out of 20 days. The resident participated in "1 to 1 activities" 1 out of 20 days. No activities were documented on 1 of 20 days. e. Further review of the medical record review showed no evidence an assessment was completed with the resident or family to ensure an individualized activity program was provided. 3. Review of the quarterly MDS assessment dated 5/02/16 showed resident #36 was severely cognitively impaired. Review of the annual MDS assessment dated 11/17/15 showed the activity assessment was not completed with the resident or family; however, the staff portion was completed. Review of the activity participation for the resident from 6/1/16 to 6/20/16 showed the facility documented that 2 activities were offered per day at 9 AM and 3 PM. Review of the activities care plan showed the resident had interventions that included: daily social interaction, supply picture books and activities when sitting at [the] table, enjoys hand massages and sensory games, assist with transporting and any help during activities, and [his/her] family visits often. The following concerns were identified: a. Review of the 9 AM activity participation log for June 2016 showed the scheduled activities were "Reminisce" on Monday, "Manicures" on Tuesday, "Crafts" on Wednesday, "Games" on Thursday, "Hand Massage" on Friday,	F 248		

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F 248	Continued From page 12 "Exercises" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. b. Review of the 3 PM activity participation log for June 2016 showed the scheduled activities were "Games" on Monday, "Crafts" on Tuesday, "Manicures" on Wednesday, "Reminisce Group" on Thursday, "Cookie Social" on Friday, "Movie" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. c. Review of the 9 AM activity participation record showed the resident participated in "music" 9 out of 20 days. The resident participated in activities titled "1 to 1 activities", "patio", and "baby" on 4 out of 20 days. No activities were documented 7 out of 20 days. d. Review of the 3 PM activity participation record showed the resident participated in family visits, "patio", and socializing 14 out of 20 days. The resident participated in activities titled "magazine" or "reading" 4 out 20 days. No activities were documented 2 out 20 days. e. Further medical record review showed no evidence an assessment was completed with the resident or family to ensure an individualized activity program was provided. 4. Review of the quarterly MDS assessment dated 4/23/16 showed resident #41 was moderately cognitively impaired with a BIMS (brief interview for mental status) score of 9 out of 15. Review of the 6/15/16 activity assessment showed it was not completed with the resident or family; however, the staff portion was completed. Review of the activity participation for the resident from 6/1/16 to 6/20/16 showed the facility documented that 2 activities were offered per day at 9 AM and 3 PM. Review of the activities care	F 248		

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F 248	Continued From page 13 plan showed the resident had interventions that included: invite to all activities, likes to choose [his/her] daily activities, offer assistance whenever needed, daily social visits, help with transporting, and family visits often. The following concerns were identified: a. Review of the 9 AM activity participation log for June 2016 showed the scheduled activities were "Reminisce" on Monday, "Manicures" on Tuesday, "Crafts" on Wednesday, "Games" on Thursday, "Hand Massage" on Friday, "Exercises" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. b. Review of the 3 PM activity participation log for June 2016 showed the scheduled activities were "Games" on Monday, "Crafts" on Tuesday, "Manicures" on Wednesday, "Reminisce Group" on Thursday, "Cookie Social" on Friday, "Movie" on Saturday, and no activity on Sunday. The resident participated in the scheduled activity 0 out of 20 days. c. Review of the 9 AM activity participation record showed the resident participated in "music" 8 out of 20 days. The resident participated in activities titled "art" and "visits" on 2 out of 20 days and was document as out of the facility on 2 out of 20 days. No activities were documented 8 out of 20 days. d. Review of the 3 PM activity participation record showed the resident participated in "family visits" and "socializing" 7 out of 20 days. The resident participated in activities titled "music" 4 out of 20 days, "one on one" 2 out of 20 days, and was documented as out of the facility 2 out of 20 days. No activities were documented 5 out 20 days. e. Further medical record review showed no evidence an assessment was completed with the	F 248		

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F 248	Continued From page 14 resident or family to ensure an individualized activity program was provided. 5. Interview with family member #1 on 6/23/16 at 10:30 AM revealed the CNAs in the secure unit provided the activities; however, there were not enough of them to provide care and activities. Further, the family member revealed concerns that there were not a lot of spiritual activities for the residents in the secure unit and there had been very few activities performed when s/he visited. 6. Review of the quarterly MDS assessment dated 6/4/16 showed resident #56 was cognitively intact with a BIMS score of 15 out of 15. Review of the annual MDS assessment dated 12/7/15 showed the activity assessment was completed with the resident and the resident identified activities as being very important. The following concerns were identified: a. Interview with resident #56 on 6/22/16 at 1:55 PM showed s/he gets bored frequently due to scheduled activities getting canceled. The resident stated there were no activities on weekends except for movies that are played repeatedly, and church services. The resident further stated that the facility was "like a morgue" on weekends. The resident expressed a desire for more activities which involved animals. 7. Review of the June 2016 activity calendar showed the only activity scheduled on Saturdays was "Movie" for 2 PM. The only activity scheduled for Sundays was church services. 8. Review of the quarterly MDS assessment dated 6/4/16 showed resident #75 was cognitively intact with a BIMS score of 13 out of 15. Further,	F 248		

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F 248	Continued From page 15 review showed the activity assessment was not completed with the resident or family; however, the staff portion was. The following concerns were identified: a. Review of the resident's daily activity documentation for 4/4/16 through 6/21/16 showed 17 of 40 documented activity days where no activity participation was documented. Further, there was no documentation to show why the resident didn't participate. 9. During a confidential interview with 14 residents on 6/21/16 at 2:30 PM, it was revealed scheduled activities were often canceled. All 14 residents indicated they had activities they wished to attend that were canceled. They further revealed they felt there were not enough activities staff to provide activity programs. 10. Review of the activities records for June 2016 showed activities were cancelled 37% of the time. 11. Interview with the activities director on 6/23/16 at 12:50 PM revealed the activities staff is also responsible for driving the facility bus and confirmed that some of the activities have been canceled. 12. Review of the facility policy titled "Resident Activity" revised 12/09 showed "...Policy: Activities shall be appropriate to meet the needs, abilities, and interests of each resident. They shall be provided in individual and group settings for ambulatory and non-ambulatory residents...The Activity Coordinator will develop, document and maintain an activities program. Sufficient number of support staff and volunteers shall be available to meet the activities needs of all residents. Each resident's activity plan shall be part of the overall	F 248		

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F 248	Continued From page 16 plan of care. The development of each resident's daily activity plan shall include consideration of mental and physical abilities, individual interest, former lifestyle, and physician recommendation....Procedure: 1. Initial interview and documentation in chart for new residents will be done within 5 working days of admission. Activity assessment to be completed within 2 weeks of admission. 2. If a resident is not able to communicate, a family member will be interviewed instead. Resident interest and needs will be determined in preparation for the development of the Activity Plan...4. Quarterly review progress notes will be done in conjunction with care plan meetings to reflect quantity, quality and any changes in participation. New goals may be set at that time as other goals have been met or were unattainable. 5. Progress notes will be written in addition to the quarterly reviews whenever a resident's condition warrants a notation or if there is a significant change...7. Resident activity therapy needs will be reflected on the resident plan of care..."	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a sanitary and well-maintained environment in 2 of 3 resident units (unit 1, unit 2). The findings were:	F 253	The facility will continue to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	8/7/2016

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F 253	Continued From page 17 1. Observation on 6/23/16 at 8:25 AM showed the bathroom in room 9 had a gouge in the wall that measured 24 inches by 2 inches which exposed an unsanitizeable underlying surface. Further, the bathroom cabinet had a drawer with a chip in the laminate that measured 8 inches by 2 inches which exposed the underlying wood and created an unsanitizeable surface. 2. Observation on 6/23/16 at 8:30 AM showed the bathroom in room 8 had a gouge in the wall that measured 24 inches by 2 inches which exposed an unsanitizeable underlying surface. Further, the bathroom cabinet had a chip in the laminate on the corner that measured 1 inch by 1 inch which exposed underlying wood and created an unsanitizeable surface. 3. Observation on 6/23/16 at 8:32 AM showed the bathroom cabinet in room 11 had a chip in the laminate that measured 10 inches by 1 1/2 inches which exposed underlying wood and created an unsanitizeable surface. 4. Observation on 6/23/16 at 8:35 AM showed the bathroom cabinet in room 17 had a chip in the laminate on the corner that measured 5 inches by 1 inch which exposed underlying wood and created an unsanitizeable surface. 5. Observation of the main dining room on 6/23/16 at 8:45 AM showed 3 tiles that each measured 6 inches by 6 inches were broken, chipped, or cracked and visibly dirty with an unsanitizeable surface. 6. Observation of the second floor meal service area on 6/23/16 at 8:50 AM showed the wall had 3 damaged areas to a corner near the dining	F 253	1. The wall in the bathroom in Room 9 was repaired on 6/24/2016, and wall protection was added to prevent future damage to the wall. The facility has contracted with a cabinet maker who is fabricating a new bathroom cabinet for this room, which will be completed by 7/29/2016. 2. The wall in the bathroom in Room 8 was repaired on 6/24/2016, and wall protection was added to prevent future damage to the wall. The facility has contracted with a cabinet maker who is fabricating a new bathroom cabinet for this room, which will be completed by 7/29/2016. 3. The facility has contracted with a cabinet maker who is fabricating a new bathroom cabinet for Room 11, which will be completed by 7/29/2016. 4. The facility has contracted with a cabinet maker who is fabricating a new bathroom cabinet for Room 17, which will be completed by 7/29/2016. 5. New tiles were installed on 6/24/2016 to replace the 3 damaged tiles in the main dining room.	

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F 253	Continued From page 18 room entrance. Area #1 was 5 inches up from the floor and measured 6 inches by 2 inches with exposed metal and underlying drywall. Area #2 was 19 inches up from the floor and measured 2 inches by 1 inch with exposed metal and underlying drywall. Area #3 was 31 inches up from the floor and measured 5 inches by 2 inches with exposed metal and underlying drywall. 7. Interview with the maintenance director on 6/23/16 at 9:30 AM revealed the facility had identified some of the areas; however, there was no timeline for correction. Further, it was confirmed that the areas were visibly dirty and unsanitizeable.	F 253	6. The wall near the second floor dining room entrance was repaired and a corner guard installed on 6/24/2016. 7. Staff will be educated to complete a work order notifying the maintenance department of any damaged areas in the facility that need repair. 8. The Director of Plant Operations will monitor the provision of adequate housekeeping and maintenance services on a quarterly basis by conducting Environment of Care (EOC) rounds throughout the building. 9. The results of EOC rounds will be reported to the EOC Committee quarterly and the minutes of those committee meetings are provided to the facility-wide Performance Improvement/Quality Improvement (PI/QI) Committee for advisement. 10. The Director of Plant Operations will monitor.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure required assistance for eating was provided during 1 of 6 meal observations (affecting resident #32). The findings were: 1. Review of the 5/3/16 quarterly MDS assessment showed resident #32 had diagnoses that included depression and hemiplegia. Additionally, the resident's cognitive abilities were assessed to be moderately impaired for daily	F312	The facility will ensure that assistance for eating is provided for residents who require such assistance.	8/7/2016

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F 312	Continued From page 19 decision making. Further review showed s/he required set up assistance and supervision with eating. Review of the 4/28/16 care plan showed the resident had diagnoses that included dementia, hydrocephalous, and a history of transient ischemic attacks. Review of the ADL care plan showed the resident required "Set up for eating and drinking, assist as necessary." The following concerns were noted: a. Observation on 6/23/16 at 9:33 AM showed resident #32 sitting at a table in the milieu with a plate of scrambled eggs and a pancake cut into bite-sized pieces. Further observation showed the resident leaning to the right in the wheelchair, attempting to pick up scrambled eggs with his/her fingers. Interview with the resident at that time revealed s/he needed help with the meal, stating "I can't feed myself and I'm hungry." The resident further stated s/he had been "waiting here a while." Two aides and a nurse were observed in the milieu at this time. The surveyor then approached CNA #3 to request assistance. The CNA was observed to reposition the resident upright in the wheelchair and then kneel down to assist the resident. b. Interview with CNA #3 at 9:37 AM revealed the resident had been in the dining room, but needed to go back to his/her room to use the toilet. She added the breakfast tray was brought to the milieu for the resident to eat there. She further stated the resident had been sitting at the table with the food for approximately 30 minutes. c. Observation at 9:47 AM showed CNA #3 assisting the resident with the food, with approximately 70% of the meal eaten. d. Interview with the DON on 6/23/16 at 12:05 PM verified staff "should not have left [the resident] sitting at the table" without ensuring proper positioning or checking if s/he required	F 312	1. Resident #32 will have a new dining assessment completed to determine the level of assistance needed with the Activity of Daily Living (ADL) of eating. The results of this assessment will be reflected on the resident's comprehensive care plan and the CNA care sheet (kardex) utilized by staff caring for the resident. 2. Resident #32 will be monitored on a daily basis at mealtimes by the charge nurse, and at least three times per week by the DON, Registered Dietitian, or Staff Development Coordinator (SDC) to ensure proper positioning and adequate assistance with the meal is provided. 3. The nursing staff will be further educated by the Administrator and Director of Nursing regarding care practices to ensure residents receive the necessary services required for completion of ADL's, including assistance for eating	

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F 312	Continued From page 20 assistance with the meal.	F 312	4. The DON, Registered Dietitian, or Staff Development Coordinator will observe at least five meals per week throughout all dining areas to ensure all residents' positioning and assistance with eating is adequate to meet their ADL needs . 5. The results of these observations will be reported to the facility's PI/QI Committee on a quarterly basis until 100% compliance is achieved for three consecutive quarters, and then periodically to ensure sustained compliance. 6. The DON will monitor.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of manufacturer's recommendations, and medical record review, the facility failed to ensure half side rails were assessed for safety for 6 of 12 sample residents (#36, #41, #45, #49, #50, #65) who used side rails. In addition, the facility failed to ensure 2 of 4 observations of lift transfers were done safely which affected residents #36 and #45. The findings were: Related to side rails: 1. Review of an annual MDS assessment dated 5/12/16 showed resident #45 was severely cognitively impaired with short term and long term memory problems. The resident had diagnoses that included non-Alzheimer's dementia. Observation on 6/23/16 at 9:18 AM showed the resident was in bed with a side rail in place on the outside of the bed and the other side of the bed was against the wall. The device was designed to have 2 gaps between the bars which were large enough for the resident to place his/her limb	F 323	The facility will ensure that the resident environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. 1. A new comprehensive side rail assessment will be conducted on the use of half side rails for residents #36, #41, #45, #49, #50 and #65, and the results of these assessments will be reflected on the residents' comprehensive care plan, including any associated risks from the use of the rails.	8/7/2016

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

A 7/22/16

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 through. The gaps measured 5 1/2 inches by 4 inches. Review of the resident's medical record showed no evidence that a safety assessment was completed. Additionally, the use of the side rail was identified on the care plan; however, it did not address the resident's safety risk including potential limb entrapment. 2. Review of a quarterly MDS assessment dated 5/2/16 showed resident #36 was severely cognitively impaired with short term and long term memory problems. The resident had diagnoses that included dementia. Observation on 6/23/16 at 9:14 AM showed the resident had a side rail in place on the outside of the bed, and the other side of the bed was against the wall. The device was designed to have 6 gaps between the bars which were large enough for the resident to place his/her limb through. Two of the gaps measured 3 inches by 3 inches and 4 gaps measured 3 inches by 12 inches. Review of the resident's medical record showed no evidence that a safety assessment was completed. Additionally, the use of the side rail was not identified on the care plan and the care plan did not address the resident's safety risk including potential limb entrapment. 3. Review of a quarterly MDS assessment dated 4/23/16 showed resident #41 was moderately impaired with a BIMS (brief interview for mental status) score of 9/15, indicating moderate cognitive impairment. The resident had diagnoses that included dementia without behaviors and schizophrenia. Observation 6/23/16 at 9:16 AM showed the resident had a side rail in place on the outside of the bed, and the other side of the bed was against the wall. The device was designed to have 2 gaps between the bars which were large enough for	F 323	2. If the half side rails continue to be used by residents #36, #41, #45, #49, #50 and #65, they will be modified for safe use. If the rails are unable to be safely modified by a cover or other means, they will be firmly secured in the down position so they are unable to be raised, or removed from the beds. 3. Any resident who uses side rails will be assessed for safety of use, and the results of the assessment will be reflected on the residents' comprehensive care plan, including any associated risks from the use of the rails. 4. All beds with side rails will be inspected for safety, and any rails with openings large enough to pose an entrapment risk will be safely modified, firmly secured in the down position so they are unable to be raised, or removed from the beds. 5. CNA #4 and CNA #5 will be provided one-to-one education regarding safe utilization of lifting devices as per manufacturer's instructions. 6. The use of lifting devices for the transfers of residents #36 and #45 and other dependent residents for toileting will be monitored by the charge nurses for safe practice.	

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F 323	Continued From page 22 the resident to place his/her limb through. The gaps measured 5 1/2 inches by 4 inches. Review of the resident's medical record showed no evidence that a safety assessment was completed. Additionally, the use of the side rail was not identified on the care plan and the care plan did not address the resident's safety risk including potential limb entrapment. 4. Observation on 6/23/16 at 11:15 AM showed resident #49 had bedrails that had a 2.5 inch gap a closed fist could easily be inserted. Medical record review showed the facility failed to assess the bedrail for safety. 5. Observation on 6/23/16 at 11:17 AM showed resident #50 had bedrails that had a 2 inch gap where a closed fist could easily be inserted. Interview with the resident during the observation revealed s/he had gotten his/her head stuck between the bedrail and mattress several times. Medical record review showed the facility failed to assess the bedrail for safety. 6. Observation on 6/23/16 at 11:20 AM showed resident #65 had bedrails that had a 2.5 inch gap where a closed fist could easily be inserted. Medical record review showed the facility failed to assess the bedrail for safety. 7. Interview with the DON on 6/23/16 at 10:45 AM revealed the side rails should have been assessed and care planned to ensure resident safety. Further, it was confirmed that the gaps in the side rails were large enough for a resident's limb to become entrapped. Related to the lift transfers:	F 323	7. Staff education will be provided regarding the necessity of side rail assessments for accident prevention, and how interventions for the use of side rails are to be reflected on the residents' care plans for their safety. 8. Education will be provided to all nursing staff regarding safe utilization of lifting devices, and not leaving cognitively impaired residents unattended in the bathroom. 9. The results of the side rail assessments, bed rail inspections, and monitoring of the use of lifting devices for residents' transfers for toileting will be reported to the facility's PI/QI Committee on a quarterly basis. 10. The DON will monitor.	

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F 323	Continued From page 23 8. Observation on 6/21/16 at 11:26 AM showed CNA #4 and CNA #5 transferred resident #36, with a "Sara Lite" sit-to-stand mechanical lift, from the resident's wheelchair to the toilet. The lifting device used a sling system that was placed behind the resident and secured around the resident's trunk. After the resident was placed on the toilet, CNA #4 locked the lift brakes and left the room at 11:30 AM, leaving the resident secured to the lift with the brakes locked. CNA #5 returned to the room at 11:34 AM, 4 minutes later, and assisted the resident off the toilet. Observation on 6/21/16 at 1 PM showed CNA #5 transferred resident #45, with a "Sara Lite" sit-to-stand mechanical lift, from the resident's wheelchair to the toilet. After the resident was place on the toilet, CNA #5 locked the lift brakes and left the room at 1:08 PM, leaving the resident secured to the lift with the brakes locked.. At 1:15 PM, 7 minutes later, CNA #5 returned to the room and assisted the resident off the toilet. The following concerns were identified: a. Review of the "Sara Lite Instructions for Use" received from the facility on 6/23/16 showed "...Correct Use of the Brakes...Brakes should only be used in the following situations: When raising the patient from a bed or chair. When the lift and the patient are momentarily at rest; for example, while preparing for transfer to a bed or a chair. Whenever movement of the lift has to be halted while transferring a patient..." b. Review of the "EZ way smart stand" lift instructions received from the facility on 6/23/16 at 11 AM showed "...Safety notes...The only time you should lock the wheels of the EZ Way Smart Stand when in use is when raising or lowering a patient during ambulation. Refer to the instructions for using the EZ Way Smart Stand for ambulation on page 7..."	F 323		

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F 323	Continued From page 24 9. Interview with the DON on 6/23/16 at 10:45 AM revealed residents should not be left unattended while attached to the lift as it could increase the risk of injury to the resident.	F 323		
F 387 SS=E	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 staff interview and medical record review, the facility failed to ensure residents were seen by a physician as required for 4 of 14 sample residents (#24, #32, #45, #50). The findings were: 1. Review of the medical record for resident #24 showed s/he was seen by a physician on 3/3/16, and not again until 6/9/16, a period of 98 days between visits. 2. Review of the medical record for resident #32 showed no evidence of physician visits between 8/15/15 and 12/6/15 (113 days), and 2/16/16 and 5/15/16 (89 days). 3. Medical record review showed resident #45 was seen by a physician on 11/14/15. The next	F 387	The facility will ensure that each resident will 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. 1. Resident #24 is now current with the physician's visit of 6/9/2016. 2. Resident #32 will have a physician's visit no later than 7/24/2016. 3. Resident #45 is now current with the physician's visit of 7/10/2016. 4. Resident #50 is now current with the physician's visit of 5/27/2016, and will have another physician's visit within ten days of 7/26/2016. 5. All residents will be monitored on a monthly basis to ensure that physician's visits are made timely, and physicians notified of any visits that are approaching an overdue date.	8/7/2016

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F 387	Continued From page 25 documented visit was not performed until 1/31/16, 78 days later. 4. Interview with the DON on 6/23/16 at 10:45 AM revealed physician visits should have been completed more frequently.	F 387	6. The contracts of employed and contracted physicians who provide care for the facility's residents were amended 7/1/2016 to specifically address the requirement for physician visits on a timely basis. 7. The facility's Medical Director will be notified of any physician non-compliance with required visits. 8. The timeliness of physicians' visits will be reported to the facility's PI/QI Committee and the Board of Trustees on a quarterly basis. 9. The administrator will monitor.	
F 441 SS=D	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.	F 441	The facility will ensure that proper infection control procedures are followed during all patient care services, including care of residents with urinary catheters. 1. The care of Resident #9 will be monitored by the charge nurses specifically during transfers involving positioning of the resident's catheter. CNA #6 will be provided one-to-one education regarding infection control practices specific to catheter care and hand hygiene.	8/7/2016

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F 441	Continued From page 26 (c) Linens 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 observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure proper infection control procedures during catheter care for 2 of 4 sample residents (#9, #49) with urinary catheters. The findings were: 1. Review of the 6/16/16 care plan showed resident #9 had diagnoses that included long-standing paraplegia and neurogenic bladder, required a full lift for transfers, and had an indwelling catheter. Further review of the indwelling catheter care area showed "Keep drain bag lower than bladder." Observation on 6/22/16 at 5:14 PM showed resident #9 requested to get up from bed to the wheelchair. CNA #6 brought in a full mechanical lift and placed the transfer sling around the resident. The CNA lifted the resident's urine collection bag above the resident's bladder and hooked it to the lift bar, at the level of the resident's chest. It remained hooked on the lift during the transfer, with urine visible in the tubing. 2. Observation of resident #49 in the shower room on 6/21/16 revealed the following infection control concerns: a. Observation on 6/21/16 at 10:20 AM showed CNA #8 and #7 used a full body lift to transfer the resident from his/her wheelchair to	F 441	2. The care of Resident #49 will be monitored by the charge nurses specifically during transfers involving positioning of the resident's catheter. CNA's #8 and #7 will be provided one-to-one education regarding infection control practices specific to catheter care and hand hygiene. 3. Nursing staff will be provided education regarding proper infection control procedures for the care of residents with urinary catheters, including positioning of the urine collection bag below the bladder, and appropriate performance of hand hygiene associated with this care. 4. The DON and Staff Development Coordinator-RN will conduct observations at least weekly of the care of Resident #9, #49, and any other resident with a urinary catheter, to ensure proper infection control procedures are being followed. 5. The results of these observations will be reported to the facility's PI/QI Committee on a quarterly basis until 100% compliance is achieved for three consecutive quarters, and then periodically to ensure sustained compliance. 6. The DON will monitor.	

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F 441	Continued From page 27 the bathtub in the shower room. CNA #8 hooked the resident's urinary drainage bag to the lift, above the resident's bladder and shoulder where it remained throughout the transfer. The urinary drainage bag and tubing had urine inside, and the tubing was observed to have backflow. At that time, the CNA used her bare hands to take the urinary drainage bag off of the lift, then touched the resident's shoulder without washing hands, and left the shower room at that time without performing any hand hygiene. Interview with the CNA immediately after she left the shower room confirmed she understood the requirement to perform hand hygiene; however, she was unaware that placing a urinary drainage bag above the resident's bladder was an infection control issue. b. Observation on 6/21/16 at 10:40 AM showed CNA #7 placed the resident's urinary drainage bag on a full body lift above the resident's bladder and above shoulder height, and attached the bag to the top of the mechanical lift while transferring the resident from the bathtub to the wheelchair. At that time, CNA #7 adjusted the catheter, tubing and collection bag with her bare hands and adjusted the resident's incontinence brief, elastic thigh band for catheter tubing security, and clothing without performing hand hygiene. The CNA then placed the urinary drainage bag in a modesty cover and secured the cover to the resident's wheelchair. 3. Interview with the infection control nurse on 6/23/16 at 10:30 AM revealed catheter drainage bags cannot be raised above the bladder because it would increase the risk for infection. Further, hand hygiene should be performed before and after handling catheters and gloves	F 441		

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F 441	Continued From page 28 should be worn while handling catheters. According to the facility policy titled, "Hand Hygiene" last revised 5/15, under "Indications for Hand Hygiene" showed the following: "5. Hand hygiene should be performed: Before and after patient contact, after contact with a patient's intact skin, ...after handling contaminated inanimate objects."	F 441		