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

PRINTED: 09/15/2016
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
	535024	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

(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 000	INITIAL COMMENTS	F 000		
	A complaint survey was conducted in conjunction with a recertification survey by Healthcare Licensing and Surveys on 7/25/16 through 7/28/16. The complaint survey was prompted by complaint intakes #WY00002179, WY00002208, #WY00002210, WY00002215, WY00002219, WY00002235, WY00002238, WY00002251, and WY00002261. The following common abbreviations are used throughout the document: ADLs Activities of Daily Living ADON Assistant Director of Nursing CAA Care Area Assessment CNA Certified Nurse Aide DON Director of Nursing MDS Minimum Data Set RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.			
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a	F 159	F-159: FACILITY MANAGEMENT OF PERSONAL FUNDS **Corrective Actions:** Resident #104 has had their funds returned to them. **Identification of Others:** An audit was completed by the	9/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 9/23/16

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.

RECEIVED
WY Dept of Health
SEP 23 2016
Healthcare Licensing and Surveys

Accepted by Lori Kress on 9/30/16 date of Completion = 9/9/16 for all tags

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F 159	Continued From page 1 separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on financial record review and staff interview, the facility failed to properly account for and return monies paid to the facility on the resident's behalf after the resident had	F 159	BOM to determine if any other past residents are owed monies not refunded timely. Those found to not have had a timely refund have been remedied. **System Corrections:** The BOM will be educated on the facilities policy on refunding monies owed to discharged residents by the Administrator. The BOM will develop a tickler file on discharged residents and follow the facilities policy on refunding discharged residents. **Monitoring:** The BOM or designee will audit discharged resident's financial files for any monies owed not returned timely per policy weekly for one month then bi-monthly until resolved. The Administrator or designee will do random audits monthly. Any non-compliance will be corrected. Results of the audit will be presented to the Monthly QAPI for effectiveness and corrective action where necessary until resolved.	

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F 159	Continued From page 2 discharged from the facility for 1 of 4 closed records reviewed (#104). The findings were: Review of the Resident Account Family Member Statement provided by the facility on 7/27/16 for resident #104 showed payments were made to the facility by Social Security on 9/3/15 and 10/2/15. Interview with the business office manager on 7/27/16 at 5:45 PM revealed the resident was discharged from the facility on 8/30/15, and the facility continued to receive the resident's Social Security payments through October 2015. She further revealed the facility had failed to return the overpaid Social Security payments to the resident or the resident's representative due to a change in the facility's accounting system in October 2015, which had left her unaware the resident was owed funds.	F 159		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	F-164 PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS. **Corrective Actions:** A privacy curtain has been installed in the hall 400 shower room. **Identification of Others:** The remaining shower rooms have been checked for privacy curtains and curtains placed where necessary.	9/9/16

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F 164	Continued From page 3	F 164	**System Changes:** The Administrator or designee has educated the shower aides to ensure a shower curtain is in place in all shower rooms and report to the Administrator or designee any rooms not containing a shower curtain. Non-compliant shower rooms will be remedied at that time. **Monitoring:** The Administrator or designee will monitor the shower rooms for privacy curtains weekly for one month then monthly thereafter until resolved. A report of noncompliance will be reported to the QAPI committee for effectiveness and corrective actions where necessary until resolved.	

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another ~~healthcare institution; law; third party payment~~ contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, and staff interview, the facility failed to ensure privacy curtains were in 1 of 4 shower rooms. This failure resulted in lack of privacy for 1 of 1 sample resident (#1) observed receiving a shower. The findings were:

Review of the 6/28/16 quarterly MDS assessment showed resident #1 had an ADL self-care performance deficit due to Parkinson's Disease. Review of the 5/23/16 care plan showed the resident required extensive assitance with bathing and personal hygiene care. On 7/26/16 at 8:15 AM, CNA #1 and RN #1 were observed assisting the resident in the shower room. Continued observation revealed the shower curtain that provided privacy for the resident was missing. Further observation revealed RN #1 departed after the resident was positioned in the shower chair. When RN #1 opened the door, the undressed resident was visible from the hallway. Interview with the CNA at that time revealed she did not know how long the curtain had been

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F 164	Continued From page 4 missing. During an interview on 7/26/16 at 9:10 AM, the administrator verified the shower curtain was necessary for privacy. He further stated the curtain was possibly removed for cleaning and had not been replaced.	F 164		
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, staff and resident interview, and medical record review, the facility failed to ensure measures to maintain dignity were effectively maintained for 1 of 18 sample residents (#53) and 1 non-sample resident (#15) observed during meal time. The findings were: 1. Review of the medical record showed resident #15 required assistance with eating due to a stroke and left sided impairment. Observation on 7/25/16 at 5:25 PM revealed the resident was served a single hot dog without a bun on a plate with no other food items. Continued observation revealed the resident made repeated stabbing motions in attempt to slice the hot dog with his/her one hand. Further observation revealed another resident seated at the same table intervened and sliced the hot dog for resident #15. At 5:40 PM, the social services director wheeled resident #15 out of the dining room to adjust his/her oxygen and returned at 5:50 PM. At that time, the resident was positioned at the table	F 241	**F-241: DIGNITY AND RESPECT OF INDIVIDUALITY.** **Corrective Action:** Staff has been educated to ask resident #15 if she would like assistance with cutting up her food when it is delivered. Resident #53 had his therapy scheduled at a time amenable to him. Resident was discharged on 8/4/16. **Identification of Others:** An audit was completed by the Therapy Manager or designee to determine who requires assist with meal set up. Those found to need assist with meal set up have had their care plans updated and staff educated on the care plan and resident needs. The Therapy Manager or designee has interviewed current residents	9/9/16

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F 241	Continued From page 5 and resumed eating the partially eaten cold hot dog. Staff did not offer a substitute or reheat the hot dog. 2. Review of the medical record showed resident #53 was admitted to the facility on 7/13/16 with diagnoses that included peripheral vascular disease, a below the knee amputation and Diabetes. This review also showed a physician's order, dated 7/14/16, for therapy 6 days a week for 8 weeks. Interview with the resident on 7/26/16 at 5:30 PM revealed the following concerns: The therapy staff did not have scheduled times for providing therapy services. This lack of scheduled time made it difficult for the resident to make plans for the day. The resident did not want to become involved in activities, visiting with other residents or watching a television show and be interrupted for therapy. Therefore, at times s/he sat in the wheelchair waiting for hours until the therapist could provide his/her therapy. The resident had spoken to the therapy staff about how this upset him/her, but they had ignored him/her. The resident stated this lack of caring about his/her feelings, "makes me feel like I am a piece of nothing, like I am not human". Interview on 9/27/16 at 9:25 AM with the director of rehabilitation services, physical therapist #1, and a certified occupational therapy assistant #1, revealed the therapy staff were aware of how the unscheduled therapy times upset the resident but they had not addressed this concern. At that time the director stated arrangements could be made to better accommodate the resident's desire to have a more narrowed timeframe for his/her therapy.	F 241	who are participating in Therapy regarding a scheduled therapy times. Those who requested a scheduled time has had it scheduled. **System Changes:** Staff has been educated on meal set up as well as offering a new meal or warming up their plate if the resident is pulled from the dining room for a period of time by the SDC. Staff will ask residents for assistance with meal set up when delivering their meals and set up those who are care planned. The Therapy Manager educated staff to ask residents who have orders for therapy if they would like a scheduled time for therapy during the initial evaluation. **Monitoring:** The Therapy Manager or designee will monitor the dining services for compliance with meal set up for those who are in need and their dignity and respect of the resident 5 times weekly until resolved. Non-compliance will be addressed timely and a report will be presented to the monthly QAPI committee for review and corrective action where necessary	

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F 250	Continued From page 6	F 250	until resolved.The Therapy Manager or designee will audit the	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to ensure medically-related social service needs were met for 1 of 18 sample residents (#42). The findings were: Review of the 1/29/16 physician's progress note showed resident #42 had presented for a cataract evaluation. The note further revealed the cataract surgery was not being scheduled at that time, and the physician recommended the resident return for a visual field test. Further review of the medical record showed no evidence the visual field test had been scheduled or performed. Interview with the resident on 7/28/16 at 3:32 PM revealed s/he was "...begging them to take the cataracts out - at least try. I want to see if it helps with my vision." Interview with the social worker on 7/27/16 at 5:11 PM revealed he did not know if the follow-up appointment for the visual field test had actually occurred. He stated he had looked at the calendar, and an appointment had been scheduled for 2/23/16, but he did not know if the resident had actually gone to the appointment or	F 250	evaluations weekly for compliance until resolved. Non-compliance will be remedied timely. A report will be presented to the monthly QAPI committee for effectiveness and corrective actions made where necessary until resolved. **F-250: PROVISION OF MEDICALLY RELATED SOCIAL SERVICES** **Corrective Actions:** Resident #42 has had their Visual Field test done on 2/28/16. **Identification of Others:** The SSD has completed an audit of appointments made for residents regarding their vision for follow up appointments for the past 60 days. . Appointments missed or not made were remedied . **Systemic Changes:** Staff has been educated on the process of making follow up appointments and the facilities procedure on tracking the appointments to ensure they were kept. SSD or designee has developed a tickler file to track	9/9/16

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F 250	Continued From page 7	F 250	appointments made and ensure any follow up appointments ordered	
	if the test had been performed. He further stated the facility did not have a system in place for tracking appointments and recommendations made at appointments to ensure they were scheduled and completed.		will be made and kept. **Monitoring:** The Administrator or designee will review a weekly report prepared by the SSD or designee for compliance. Non-compliance will be remedied timely. The reports will be presented to the monthly QAPI committee for effectiveness	
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.	F 253	and corrective action necessary until resolved. **F-253: HOUSEKEEPING AND MAINTENANCE SERVICES** **Corrective Actions:** The floors in the 100, 200, 300, 400, 500, 600 hallways, the Main Dining area, the Sunflower Room, the Dining area in the Secured unit, the Activity room, and the carpet in the television room will have an abatement request submitted and a contract in place to complete the repair/replacement of the flooring and transition strips on or before 9/9/16 with completion of the flooring done within 45 days. The push pins in the baseboard have been removed and the baseboard affixed. The dirt and debris on the	9/9/16
	This REQUIREMENT is not met as evidenced by: This requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment in 3 of 4 shower rooms, 1 of 1 activity room, 3 of 3 dining rooms, and 6 of 6 hallways. The findings were: Observation on 7/25/16 at 2:45 PM and again on 7/28/16 at 8:05 AM revealed the following concerns: 1. 100 hallway: a. A gouge in the floor tile that measured 1 and 1/2 inches by 2 inches and 1/4 inch deep was located between room 107 and 108. b. A cracked floor tile in front of the rear exit door measured 3 inches long. c. Floor tiles to the left of the entryway to room 107 had a 3 inch crack and a 2 inch crack that radiated in a spider web pattern. d. Cracked floor tiles spanned the length of the hall between rooms 105 and 106. e. A split transition strip between the tiled			

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F 253	Continued From page 8 floor and the wood grained floor contained an accumulation of dirt and debris. 2. 200 hallway: a. A split transition strip between the tiled floor and the wood grained floor contained an accumulation of dirt and debris. b. A split transition strip at the entry to the shower room contained an accumulation of dirt and debris. c. Resident room 206 was missing a transition strip between the bathroom and living area. 3. 300 hallway: a. Cracks in the floor tiles near room 306 spanned six 12 by 12 inch tiles. b. A split transition strip at the base of the fire doors contained an accumulation of dirt and debris. c. A transition strip was missing from the entrance to room 309. d. Five out of 6 cracked floor tiles spanned the width of the hallway between rooms 303 and 310. e. The inside of the bathroom door of resident room 303 had a crack that measured 7 inches long and 1 inch wide. f. Resident rooms 304, 307, and 308 were missing a transition strip between the bathroom and living areas. g. The sink in room 301 was slow to drain. 4. 400 hallway: a. The transition strips at the entrance to room 405 and 413 were split and contained an accumulation of dirt and debris. b. The sink in room 410 was slow to drain.	F 253	lower sills of the entrance doors to the room and the vent have been cleaned as have the insects on the wall, crevices and window frame. The wax and dirt build up in the Sunflower Room has been cleaned. The inside bathroom door in room 303 had the crack repaired. The sink in room 301, and 401 had its drain fixed. The drain access cover in room 609 has been repaired. The Shower room in the 600 hallway has had the grab bar and the wall on the base of the tub repaired and the shower room deep cleaned to include the shower curtain. The Shower room in the 200 hallway has had the toilet replaced and the baseboard repaired. The Shower room in the Secured Unit has had the stored items removed and has had the cracked tiles repaired. The Shower room in the Secured Unit has been deep cleaned. **Identification of Others:** The Maintenance Director or designee has rounded the facility for flooring in repair, tiles cracked, slow sink drains, and stained toilets throughout the facility. Areas in need of repair have had an action plan completed with timetables and	

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F 253	Continued From page 9 5. 500 hallway: a. There were two chipped floor tiles at the exit door near room 508. One measured 1/2 by 1 inch and the other 1/2 by 1/2 inch. b. Cracks in the floor tiles to the left of room 508 extended 24 inches over three 12 by 12 inch tiles. c. The entryway transition strip was missing from room 507. 6. 600 hallway: a. The floor near room 612 contained cracks that radiated in a spider web pattern on four 12 by 12 inch tiles. b. Bubbled and cracked floor tile below the hand sanitizer station near the fire door created an uncleanable surface. c. Two gouged and chipped floor tiles near the fire door divider measured 2 1/2 by 1 inches and 1/2 by 1 inch and created an uncleanable surface. d. Cracked floor tiles in front of room 604 extended over four 12 by 12 inch tiles. e. The drain access cover to the left of the sink in room 609 was loose which exposed a metal edge. In addition, the mopboard in the corner to the left of the sink was pushed back into the wall which exposed 1/2 inch of uncleanable surface. Observation on 7/28/16 at 9:05 AM revealed the following concerns in the dining and activities rooms: 1. Main dining room: a. Circular cracks at the corners of the floor tiles and linear cracks in multiple 12 by 12 inch tiles throughout the expanse of the room. 2. Sunflower dining room:	F 253	obtainable dates of completion. The Housekeeping Laundry Manager or designee has rounded the facility for areas in need of deep cleaning, wax and debris build up, or vents that need addressing. Areas found have been remedied. **Systemic Changes:** The Maintenance Director or designee will round weekly and repair items found timely. A maintenance request form has been developed and staff educated on the process to aide in the recognition and repair of areas of concern. The Housekeeping and Laundry Manager will do weekly rounds and spot check room and common areas for cleanliness, wax build up and debris throughout the facility. Any areas in need will be addressed at that time or at the earliest opportunity. **Monitoring:** The Maintenance Director and the Housekeeping and Laundry manager will present their round reports to the Administrator weekly for review and corrective actions needed. The Administrator or designee will do random rounds to ensure cleaning and repairs are	

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F 253	Continued From page 10 a. The transition strip between the dining area and the hallway was missing. b. Multiple circular cracks at the corners of the 12 by 12 inch floor tiles throughout the expanse of the room. c. Wax and dirt buildup on the mopboards underneath the radiator. 3. Dining room/television room in the secure unit: a. Linear cracks extended over 18 of 20 consecutive 12 by 12 inch floor tiles in the main dining area. b. A zigzag gouge in the floor to the right of the south exit doors extended over seven 12 by 12 inch tiles. c. A crack on the floor near the north entrance to the television room spanned the width of a 12 by 12 inch tile. d. The carpet in the television room had multiple stains of varying sizes throughout the room. The high traffic areas of the carpet and behind the recliner next to the outside exit door had stains that were uncleanable. e. The baseboard to the left of the north entrance door to the television room was held to the wall with push pins. f. The television room had dirt and debris buildup on the lower sills of the entrance doors to the room and on the vent. In addition, dead insects were on the wall and in the crevices of the window frame. g. The wall to the left of the outside exit door had multiple scrapes and peeling paint. h. The ceiling in the television room above the north window was cracked and joint tape and compound had peeled away from the surface. 4. Activity room: a. A crack in the floor extended over two 12	F 253	being completed. The results of the round reports will be presented to the Monthly QAPI committee for effective and corrective actions taken where necessary until resolved.	

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F 253	Continued From page 11 by 12 inch tiles measured 16 inches long. Observation on 7/26/16 at 8 AM and again on 7/27/16 at 4:57 PM of the shower rooms revealed the following concerns: 1. Shower room in the 600 hallway: a. A buildup of insects in two of two light fixtures. b. The wall near the base of the tub on the left hand side had discolored, moist, and disintegrated plaster that exposed the metal mesh and fell to the floor when touched. c. The grab bar to the right of the shower chair was loose. d. The bottom 6 inches of the shower curtain was black with mildew. 2. Shower room in the 200 hallway: a. The toilet bowl was stained brown. b. The baseboard around the base of the sink had pulled away from the cabinet. 3. Shower room in the secure unit: a. The room was used to store a sit-to-stand lift, 3 dining room chairs, 2 large garbage cans without bags, and a portable oxygen canister. b. The vent above the sink had a buildup of dust. c. Two toothbrushes and an uncapped toothpaste tube were laying on the sink. d. Cracked and chipped pink ceramic tiles along the base of the tubroom created an uncleanable surface. Interview with the maintenance director on 7/28/16 at 9:50 AM verified that the identified areas needed cleaned and/or repaired.	F 253		

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F 272	Continued From page 12	F 272		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 COMPREHENSIVE ASSESSMENTS **Corrective Action:** Resident #22, #42, #49, #50, #67, #72, #78 has had their Comprehensive Assessments completed and entered into their MR. **Identification of Others:** Residents with Comprehensive Assessments completed in the last 30 days will be reviewed for CAA's (Care Area Assessments) and if completed without full analysis will have care plans reviewed for thoroughness related to each resident specific condition. **System Measures:** DDCM/Designee has educated the IDT (Social Services, Activities, Dietary, MDS Staff) on the completion of CAA's and analysis of findings. DDCM/Designee will review 2 – 3 comprehensive assessments weekly for four weeks then monthly for three months for CAA completion with analysis of findings.	9/9/16

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F 272	Continued From page 13	F 272		
	This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the comprehensive assessment of resident needs in a variety of areas for 7 of 18 sample residents (#22, #42, #49, #50, #67, #72, #78). The findings were: 1. Review of the 5/28/16 admission MDS assessment for resident #49 showed the assessment triggered for further assessment of the following care areas: Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, and Pressure Ulcer. The following concerns were identified: a. Review of the CAA for ADL Functional/Rehabilitation Potential showed only "[Resident] needs assistance with ADL's r/t [related to] right sided hemiplegia, aphasic, s/p ABD [after abdominal] surgery, acute pain r/t surgery, balance issues." There was no analysis of the resident's specific needs in this area. b. Review of the CAA for Urinary Incontinence and Indwelling Catheter showed only "[Resident] has incontinence r/t impaired mobility, right sided hemiplegia, acute pain r/t surgery, S/P ABD surgery with new colostomy, urinary retention, poor balance, aphasia." There was no analysis of the resident's specific needs in this area. c. Review of the CAA for Psychosocial Well-Being showed only "[Resident] has a		Monitor: The facility will audit compliance through weekly reviews of conducted assessments. Results of audits will be reported to the QAPI for effectiveness and corrective actions taken where necessary until resolved.	

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F 272	Continued From page 14	F 272		

potential for adjustment issues in relation to his psychosocial well being." There was no analysis of the resident's specific needs in this area.

d. Review of the CAA for Behavioral Symptoms showed only "If [resident] does not understand how the staff is helping him he may become upset." There was no analysis of the resident's specific needs in this area.

2. Review of the 10/21/15 admission MDS assessment for resident #42 showed the assessment triggered for further assessment of the following care areas: Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. The following concerns were identified:

a. Review of the CAA for Cognitive Loss/Dementia showed only "[Resident] exhibits short and long term memory loss." There was no analysis of the resident's specific needs in this area.

b. Review of the CAA for ADL Functional/Rehabilitation Potential showed only "Resident needs some assistance with ADL's r/t cognition issues, use of psychoactive medications." There was no analysis of the resident's specific needs in this area.

c. Review of the CAA for Psychotropic Drug Use showed "[Resident] exhibits short and long term memory associated with her diagnosis." There was no analysis of the resident's specific needs in this area.

3. Review of the 5/13/16 admission MDS assessment for resident #22 showed the assessment triggered for further assessment of the following care areas: ADL

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F 272	Continued From page 15 Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Activities, Falls, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer, and Pain. The following concerns were identified: a. Review of the CAA for Activities showed "Resident has little interest or pleasure in doing things." There was no analysis of the resident's specific needs in this area. 4. Review of the 5/27/16 significant change MDS assessment showed resident #50 triggered in areas including: Delirium, Cognitive loss/dementia, Mood state, Psychosocial well-being, Urinary Incontinence and Indwelling Catheter, Activities, Falls, Pressure ulcer, and Psychotropic drug use. These triggered areas required additional assessment. Review of the CAAs for these areas showed they were lacking information and analysis. 5. Review of the 4/12/16 annual MDS assessment showed resident #67 triggered in areas including: Cognitive loss/dementia, Urinary Incontinence and Indwelling Catheter, Psychosocial well-being, Pressure ulcer, and Psychotropic drug use. These triggered areas required additional assessment. Review of the CAAs for these areas showed they were lacking information and analysis. 6. Review of the 7/7/16 annual MDS assessment showed resident #78 triggered in areas including: Cognitive loss/dementia, Visual function, and Nutritional status. These triggered areas required additional assessment. Review of the CAAs for these areas showed they were lacking information and analysis.	F 272		

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F 272	Continued From page 16	F 272		
	7. Review of the 3/13/16 annual MDS assessment showed resident #72 triggered in areas including: Cognitive loss/dementia, Psychosocial well-being, Behavioral symptoms, and Activities. These triggered areas required additional assessment. Review of the CAAs for these areas showed they were lacking information and analysis. ~~8. Interview with the MDS coordinator on 7/28/16~~ at 3:50 PM verified some of the CAAs were not comprehensive. The coordinator stated different departments were responsible for various CAA completion and there was a need for additional training to ensure the analysis was being done.			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 274	F-274 COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE **Corrective Action:** Resident #21 had a comprehensive assessment completed 8/2/16. **Identification of Others:** A review of residents with assessments completed within the last 30 days have been reviewed to determine if a significant change in assessment status was warranted and not completed. If one was	9/6/16

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F 274	Continued From page 17 interview, the facility failed to complete a significant change MDS assessment for 1 of 4 sample residents (#21) who required that assessment. The findings were: Review of the medical record showed resident #21 was admitted to the facility on 1/6/14 with diagnoses which included cellulitus and muscle wasting. Review of the 1/7/16 quarterly MDS assessment showed the resident required supervision with all ADLs and had no extremity impairments. Review of the 3/7/16 quarterly MDS assessment showed the resident continued to have no impaired extremities, used a wheelchair and walker, and required supervision with all ADLs except transfers required extensive assistance. However, review of the 5/16/16 quarterly MDS assessment showed the resident required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene care. This review also showed the resident had bilateral lower extremity impairments and no longer used a walker. Interview with the MDS coordinator on 7/28/16 at 5:30 PM verified the facility failed to complete a significant change MDS assessment for the resident's decline in status.	F 274	warranted and not completed an assessment was initiated and completed. **System Measures:** DDCM/Designee has educated the IDT (Interdisciplinary Team) on identification of Significant Change in Status assessments . RCMD (Resident Care Management Director)/designee will review residents for significant change in status during morning clinical meeting by reviewing clinical dashboard, orders, 24 hour report, clinical rounding as well as team discussion. **Monitor:** The facility will audit compliance through weekly reviews of conducted assessments. Results of audits will be reported to the QAPI for effectiveness and corrective actions taken where necessary until resolved.	
F 411 SS=E	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for	F 411	**F-411:** **ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS.** **Corrective Actions:** The facility has obtained an agreement for routine and emergency dental services.	9/9/16

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F 411	Continued From page 18 routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure dental services were available for 3 of 3 non-sample residents (#9, #10, #19) who needed routine dental care. The findings were: On 7/25/16 the surveyor requested evidence of the provision of dental services. On 7/26/16 at 2 PM the administrator stated they did not a have a current dental contract because it expired in March of this year. He further stated they could make arrangements for emergency dental care, but did not have a system for ensuring residents received routine dental care. Interview with the social services director on 7/28/16 at 9 AM revealed he maintained a record of residents who would receive dental care when they are able to provide this service and currently residents #9, #10, and #19 were waiting for routine dental care.	F 411	Residents #9, #10, #19 have had appointments made and kept for routine dental care. **Identification of Others:** The SSD has completed an audit of residents requesting or in need of routine or emergency dental care. Those needing dental care have had appointments scheduled. **Systemic Changes:** Staff has been educated on the process of recognizing residents in need of routine or emergency dental care and the procedure for scheduling appointments. SSD or designee has developed a tickler file to track appointments made and ensure any follow up appointments ordered will be made and kept. **Monitoring:** The Administrator or designee will review a weekly report prepared by the SSD or designee for compliance. Non-compliance will be remedied timely. The reports will be presented to the monthly QAPI committee for effectiveness and corrective actions where necessary until resolved.	
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	F 441		

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F 441	Continued From page 19 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 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, review of policy and procedure, and staff interview, the facility failed to ensure staff consistently disinfected the glucometer (device used to test blood sugar) after use for 1 sample resident (#34) and 2 non-sample residents (#23, #30) during random observations of resident testing. The findings	F 441	**F441 Infection Control, Prevent Spread** **Corrective Actions** Current LN staff has received education on glucometer cleaning between residents who require routine glucometer testing including residents #34, #23, #30. **Identification of Others** All residents have the potential to be affected by this practice. **Systemic Changes** The Staff Development Coordinator or designee will educate Licensed Nursing staff on proper decontamination procedures for glucometers, including disinfection between use with residents. The Staff Development Coordinator or designee will audit compliance through 2 random weekly observation audits per nursing unit of glucometer cleaning, including cleaning between residents for 4 weeks and then monthly for 2 months. Results of audits will be reported to the QAA committee for tracking and trending. **Monitoring** Results of glucometer cleaning audits will be reported to the QAPI committee monthly by the Staff	9/9/16

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F 441	Continued From page 20 were: Observation on 7/25/16 from 3:40 PM to 4 PM revealed RN #2 used a glucometer for testing resident #34's blood sugar level. Further observation revealed the RN used the same glucometer to for testing glucose levels for residents #23 and #30. Continued observation revealed the RN did not disinfect the glucometer at any time during the observation. After he completed the task, he placed the used glucometer into a zipped pouch. Interview with RN #2 on 7/26/16 at 9:18 AM revealed he knew the glucometer should be disinfected after use but he had forgotten to do this. Review of the Glucometer Decontamination Policy and Procedure, revised 9/2015, revealed the glucometer should be decontaminated with the facility approved wipes following use on each resident.	F 441	Development Coordinator or designee and reviewed for effectiveness and corrective actions taken where necessary until resolved.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of maintenance requests, and staff interview, the facility failed to ensure a safe and sanitary environment for staff in 2 random locations. The findings were: 1. Observation on 7/27/16 at 4:36 PM of the ceiling and the floor of the kitchen showed	F 465	**F-465: SAFE/FUNCTIONAL SANITARY/COMFORTABLE ENVIRONMENT.** **Corrective Actions:** The ceiling near the three compartment sink has been repaired.The missing tiles were replaced throughout the kitchen. The pipe under the sink has been affixed properly.The leak in the sink has been repaired The area	9/9/16

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F 465	Continued From page 21 damaged areas which were in need of repair. These areas included a section of the ceiling near the 3 compartment sink which had cracked and missing material. Three tiles on the wall near a refrigerator unit were missing and the surface underneath was unable to be thoroughly cleaned. The pipes under the 3 compartment sink were held together with black tape, and there was a leak from one of the sinks. Interview with the dietary manager on 7/27/16 at 5:15 PM verified these areas were in need of maintenance. The manager stated she had filed work orders and it was slow to get the items fixed. Review of the maintenance request log showed a request dated 6/3/16 to have the ceiling in the kitchen repaired where it was "peeling." 2. Observation on 7/27/16 at 5:20 PM showed the area surrounding the ice machine located in the secured unit was in need of maintenance. The area was located behind the nurses' station. The wall behind the ice machine was open exposing the dry wall with dark colored spots and streaks. The floor was un-clean and there were damaged tiles. Further, the area on the sides and behind the machine were cluttered with plastic bags, papers and boxes. Interview at that time with the contracted dietary services supervisor verified the area surrounding the ice machine required maintenance and cleaning.	F 465	behind the Ice Machine in the Secured unit has been repaired and the floor cleaned. **Identification of Others:** The Maintenance Director has completed a facility rounding for any areas or equipment in the kitchen and around the ice machines that are unsafe, nonfunctional, or unsanitary. Areas found were remedied. **System Changes:** The Maintenance Director or designee will round the facility weekly for any areas that are unsafe or unsanitary and equipment or fixtures that are nonfunctional or unsafe. Areas found will be remedied timely. Staff has been educated on the procedure for notifying the Maintenance Director of similar areas in order to ensure they are remedied timely. **Monitoring:** The Administrator or designee will review the maintenance logs and weekly rounds reports weekly for compliance. The Administrator will do random rounds weekly for compliance. Any noncompliance will be remedied timely. The reports will be submitted to the	
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	F 520		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 22 facility; and at least 3 other members of the facility's staff. 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, and review of previous survey results, the facility failed to ensure the quality assessment and assurance program was effective identifying and resolving recurrent problems related to dignity, social services, unsafe and unsanitary environment, pressure ulcers, and housekeeping and maintenance. The findings were: Review of findings from the facility's last surveys; dated 1/15/16 revealed the facility was cited for their deficiencies regarding dignity, social services, unsafe and unsanitary environment, and housekeeping and maintenance concerns. Review of findings from the complaint survey completed on 2/10/16 revealed the facility was	F 520	Monthly QAPI committee for effectiveness and corrective actions where necessary until resolved. **F-520: QAA Committee-Members/Meet Quarterly/Plans Corrective Action:** Performance Improvement Plans (PIP) have been written or revised to more effectively identify and correct previously identified Deficiencies. **Identification of Others:** A review of currently active PIP's related to the non-compliant areas was completed by the Administrator for effectiveness. PIP's shown to be ineffective have been revised by the QAPI members. **Systemic Changes:** The QAPI members have been educated on F-520 and the QAPI process by the District Director of Clinical Operations. An effective QAPI committee will identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implement appropriate plans of	9/9/16 TB

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F 520	Continued From page 23 cited for failure to provide appropriate care for pressure ulcers. Survey findings from this current survey showed repeat citations in all of the above areas and is evidence of the facility's inability to sustain compliance with the requirement to ensure each resident receives adequate care and services. An interview with the DON on 7/28/16 at 4 PM, revealed she had been the DON for approximately 6 months and during the time she and staff had identified problem areas including some of the deficiencies cited during this survey. She further stated systems had been developed to address problem areas, but some changes take more time than others.	F 520	action to correct identified quality deficiencies. **Monitoring** A weekly report on the progress of the QAPI program and its effectiveness will be presented to the District Director of Clinical Operations for effectiveness and corrective actions where necessary until resolved.	