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

PRINTED: 12/30/2016
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 12/15/2016

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by the Office of Healthcare Licensing and Surveys on 12/13/16 through 12/15/16. The survey was prompted by complaint intakes WY00002332, WY00002330, WY00002331, and WY00002328 The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living ~~CAA- Care Area Assessment~~ DON- Director of Nursing Services MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely ~~because it is required by the~~ provisions of federal and state law.	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157	**F 157: NOTIFY OF CHANGES (INJURY DECLINE ROOM, ETC.)** **Corrective Action** Resident #2's family was notified of the resident to resident altercation on 12/2/16 at 2p. 1:1 education will be completed with the licensed nurse involved re: timely notification of family / representative of acute change of condition / injury and documentation of notification.	1/24/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Admin 1/9/17

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
JAN 09 2017
Healthcare Licensing and Surveys

Accepted with change to pg. ~~11~~ pg 12 + pg 14
Changes made per phone call with Tony Jahn, NHA 1/23/17 @ 1:22pm

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F 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, and medical record review, the facility failed to immediately notify the resident's family/representative for 1 of 2 incidents reviewed. The findings were: Review of the incident/accident report dated 12/2/16 at 2:02 AM showed resident #2 was the victim of a resident-to-resident physical abuse incident. The resident was sitting in his/her room	F 157	**Identification of Others** An audit will be completed by Director of Nursing / designee, to identify any additional instances in which the family / representative was not notified in a timely manner of an acute change of condition or injury in the last 30 days. Corrective actions will be taken as needed. **Systemic Changes** The DON or designee will educate the licensed nursing staff, on or before date of compliance, regarding the notification of the physician and resident's family / representative of any acute changes in condition or injuries in a timely manner and noting this notification in the medical record. The Director of Nursing or designee will continue to review incident / accident reports, 24 hour report and the clinical dashboard in Point Click Care in morning meeting 3 to 4 times per week to identify any resident with acute change of condition / injury. Documentation will be reviewed for family / representative	

98

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F 157	Continued From page 2 when resident #6 came in and started hitting him/her with closed fist and ramming his/her lower legs with their walker. Review of the progress note dated 12/2/16 at 2:02 AM showed "Resident is terrified of being attacked again." Review of the nursing note dated 12/2/16 at 3:16 PM showed, "Multiple bruises noted to bilateral lower extremities (BLE) and bilateral upper extremities (BUE). Bruise noted to left temporal area, and around left eye. Skin tear noted to right shin." The following concerns were identified: a. Review of the progress report dated 12/2/16 timed at 2:02 AM showed the resident's son was notified of the incident on 12/2/16 at 2:00 PM, twelve hours after the incident which resulted in injury and fear for the resident. b. Interview with the DON on 12/15/16 at 11:00 AM revealed his expectation was for the family/representative to be notified of injury and change in condition "as soon as possible." In addition, he confirmed the facility did not have a policy related to notifying family/representatives of incidents.	F 157	notification of acute change of condition / injury in a timely manner. **Monitoring** The Director of Nursing or designee will review 10 residents with acute change of condition / injury weekly for 3 months for ~~timely family / representative~~ notification. If concerns are identified corrective action will be taken based on findings. The Director of Nursing will track and trend the results of the audits monthly and report findings to the QAPI Committee. The QAPI Committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly until resolved.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or	F 225	**F-225: INVESTIGATE REPORT ALLEGATIONS INDIVIDUALS** **Corrective Actions:** The initial report and final investigation for the resident to resident incident between residents	1/24/17

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F 225	Continued From page 3 misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect,	F 225	#2 and #6 and residents #4 and #6 has been resent to the State Survey Agency. **Identification of Others:** An audit of resident to resident incidences and abuse and neglect allegations for the last 60 days was completed. Unreported incidences ~~and/or abuse and neglect and~~ incidences of resident to resident events with serious injury will be reported by date of compliance. **Systemic Changes:** Staff and management were educated on the updated Facility Operations policy on Abuse and neglect reporting timeframes as well as the reporting time frames for resident to resident incidences including the 2 hour time frame for serious injury. The Administrator has read the State and Federal guidelines on reporting of Abuse, neglect or mistreatment and resident to resident incidences where there is serious injury. Observation or allegation of abuse, neglect or mistreatment will be reported to the Administrator and/or DON immediately but no	

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F 225	Continued From page 4 exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of medical records and facility incident/accident reports, policy and procedure review, and review of State Survey Agency records, the facility failed to ensure 2 of 2 abuse allegations reviewed were reported as required. The findings were: 1. Review of the incident/accident report dated 12/2/16 at 2:02 AM for sample resident #2, revealed the following: a. Resident #2 was sitting in his/her room when resident #6 came in and started hitting him/her with a closed fist and ramming his/her lower legs with their walker. b. Review of the progress notes dated 12/2/16 at 2:02 AM showed "Resident is terrified of being attacked again." Review of the nursing notes dated 12/2/16 at 3:16 PM showed, "Multiple bruises noted to bilateral lower extremities (BLE) and bilateral upper extremities (BUE). Bruise noted to left temporal area, and around left eye. Skin tear noted to right shin." The on-call doctor was notified at 2 AM and the son of resident #2 was notified on 12/2/16 at 2:00 PM. c. Interview with the administrator on 12/14/16 at 4:20 PM verified he intended to notify the State Survey Agency of the allegation of	F 225	later than 2 hours and then reported to the State Survey Agency immediately or no later than 2 hours. Resident to Resident incidences are to be reported to the Administrator and/or DON within 2 hours of the occurrence. The Administrator and/or DON will report the incident within 24 hours ~~or within 2 hours if serious injury~~ has occurred. **Monitoring:** The Administrator will review the 24 hour report and Incidence Reports 3 to 4 times per week during the morning management meeting for any incidences needing reporting. Any unreported incidences will be reported within State and Federal guidelines. The District Director of Clinical Operations or designee will audit the Incidence Reports twice per month for compliance. The results of the audits and reviews will be reported at the facility QAPI to review for effectiveness and corrective actions and/or changes will be made where necessary until resolved.	

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F 225	Continued From page 5 abuse, however, he had no verification of the report. Review of the incident logs maintained by the State Survey Agency failed to show the incident of abuse was reported. 2. Review of the incident/accident report showed on 12/9/16 at 7:00 PM resident #4 and resident #6 had an altercation. Resident #6 had hit resident #4 in the face twice and there were no injuries noted. Review of the progress notes on 12/10/16 3:30 AM showed, "Resident [#6] denies injury and stated s/he is the one that punched the other resident. Resident is on neuros [neurological checks] due to this and s/he has refused all vital signs tonight. No change in neuro status from his baseline. Resident is angry, inappropriate and verbally aggressive." The following concerns were identified: a. Review of the report information showed the State Survey Agency was not notified of the abuse allegation until 12/12/16. b. Interview with the administrator on 12/14/16 at 10:38 AM revealed the report of this resident-to-resident abuse incident was not submitted sooner, because he was notified of the altercation on 12/12/16. c. Review of the September 2016 "OP2 0304.00 Facility Operations" policy on abuse and neglect prohibition showed, "Any observations or allegations of abuse, neglect or mistreatment must be immediately reported to the Administrator and/or DON. The facility responds immediately to such allegations in accordance with state and federal law. "	F 225		
F 257 SS=E	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels.	F 257		

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F 257	Continued From page 6 Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and review of maintenance notes, the facility failed to ensure the temperature in 3 of 7 resident areas (secured unit/500 hall, 600 hall, main dining room) was safe and comfortable. The findings were: Observation of the secured unit/500 hall on 12/13/16 at 2:50 PM showed there were two thermostats on the wall, one near room 509 and one near the exit to the 600 hallway. The thermostat near room 509 showed 65 degrees Fahrenheit (F) when observed at 2:50 PM. The thermostat near the 600 hallway exit was digital and showed 72 degrees F when observed at 3:01 PM. The temperature of the area felt cold and the residents who were in bed were noted to have several blankets. Observation of the 600 hall on 12/13/16 at 3:04 PM showed the temperature as measured with an infrared thermometer was 69.3 degrees F and a cold draft could be felt coming from a ceiling vent in the area between rooms 611 and 602. Observation in room 601 at 3:04 PM showed the room felt cold, and the window could not fully closed or latched and leaked cold air into the room. The thermostat near the door of the room showed the temperature was 68 degrees F. Observation on 12/13/16 at 5:23 PM showed room 601 felt cold. The resident was not in the room, and there was no thermostat in the room, however, when measured with an infrared thermometer the wall by the head of the bed measured 65.5 degrees F. The window in this room was leaking cold air; a draft at the bottom of	F 257	**F-257: COMFORTABLE AND SAFE TEMPERATURE LEVELS** **Corrective Actions:** Two new pumps have been installed on the boiler that supplies hot water to the heat registers in the 500 and 600 halls to maintain a ~~temperature range between 71 and~~ 81 degrees. The vents in the 600 hallway between room 602 and 612 and the main dining room have been covered. The 601 room window was cleaned and latched and the room temperature ranges between 71 and 81 degrees. Attempts to cover the window in room 602 were refused by the resident. **Identification of Others:** Rounds were made by the Administrator and Maintenance Director to observe temperatures in the remaining hallways and to check drafts from vents. Areas not meeting the CMS temperature requirements were remedied. The water lines in the hallways were bled of air and a check of the	1/24/17

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F 257	Continued From page 7 the window could be felt. Observation of the main dining room on 12/14/16 at 4:35 PM showed the evening meal service was in process. There were 9 residents observed in the dining room wearing coats and some wore winter hats as well. Interview at that time with 2 of the residents wearing coats revealed they were cold and had been cold for several days. There was an open vent on the ceiling in the room letting in the cold air from outside. The following concerns were identified with the prolonged cold temperatures: a. Confidential interview with staff #1 on 12/13/16 revealed the cold temperatures on the 500 hallway had been ongoing since Saturday 12/10/16. The staff member stated residents were uncomfortable and extra blankets were used for warmth. However, the blankets that were available were thin bath blankets and the staff member was concerned because they were not thick warm blankets. The staff member was unsure when the administration was made aware of the heat situation. The staff stated the temperatures were cold enough to require that resident #7 be brought out of his/her room into the main area to sleep on a mattress on the floor for 2 nights (12/10/16 and 12/11/16) and be warmed up. b. Confidential interview with staff #2 on 12/14/16 revealed residents on the secured unit had been uncomfortable and complaining of the cold temperatures in the 500 hall/secured unit. The staff member reported the temperatures were uncomfortably cold on Friday 12/9/16, Saturday 12/10/16, and Sunday 12/11/16. She was uncertain of the actual temperature, however, she stated residents were shivering and had to have many extra blankets. She further stated resident #7 had been brought into the milieu to sleep on a mattress on the floor	F 257	boilers for any potential problems. No current evidence of problems noted at this time. **Systemic Changes:** Staff was educated on the need to notify the Administrator and/or Maintenance if the facility feels cold or the thermostat reads below 71 degrees. A protocol was put in place and staff educated on what to do if the facility temperature reaches 70 degrees or below. Maintenance or designee will check the temperatures twice per day to ensure temperatures are maintained between 71 and 81 degrees. Variances to these temperatures will be acted on immediately. **Monitoring:** Results of the temperature checks will be presented to the Monthly QAPI meeting for review and corrective actions if necessary.	

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F 257	Continued From page 8 Saturday and Sunday due to the resident's room being cold. c. Confidential interview with staff #3 on 12/14/16 revealed on the afternoon of 12/10/16 resident #7 was so cold in his/her room staff couldn't get a temperature to register on the resident with a forehead temperature strip. She stated the resident was brought out of the room to be warmed up and they covered the resident in blankets in a recliner. Also, she stated a temperature was taken once the resident had warmed up and she remembered it was about 95 degrees F. d. Interview with resident #4 on 12/13/16 at 3:04 PM in room 601, revealed "It [the temperature] got worse over the weekend. Because they don't care. They took all my blankets when they moved my bed over to the window. I use to have 10 now not many at all." The resident was wearing a stocking cap and an outdoor coat zipped up. Observation of the resident's room showed it was single occupancy and the bed was by the window. The window seal had multiple dried leaves stuck under the bottom edge of the crank-out portion of window. The air temperature in the room read 62.9 degrees F when measured with an infrared thermometer; there was no thermostat in the room. e. Interview on 12/13/16 at 3:04 PM with resident #1 in room 602 revealed s/he was not satisfied with the temperature of the room. It was too cold and the facility did not have thick blankets to provide. The resident was concerned because the room had been cold for days and the weather outside was expected to be even colder in the coming week. The resident stated "They keep saying they're fixing it, [but] it never is." The thermostat in the room showed the temperature was 68 degrees F.	F 257		

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F 257	Continued From page 9 f. Observation on 12/13/16 at 3:15 PM in room 611 showed an air temperature of 63.7 degrees F when measured with the infrared thermometer g. Interview with the administrator on 12/14/16 at 2:59 PM verified there had been issues with the boiler system and the temperature in the back area of the building was affected by this. The first he was made aware of the situation was the morning of 12/12/16. The administrator stated the staff working over the weekend should have notified him or the maintenance director as soon as the temperature in the facility became uncomfortable. He stated there was no temperature tracking done over the weekend or currently. Further, there was no formal emergency procedure related to heat outage other than providing extra blankets to the residents affected and getting the repairs done to the heating system. The administrator verified there were 2 boiler rooms and there was a history of break downs which had affected the heat in the past. h. Interview with the maintenance staff member on 12/15/16 at 8:55 AM revealed she was the only maintenance staff member since the maintenance director's last day on 12/5/16. The staff member verified the boiler in the back area had gone down over the weekend. She stated she was notified by a CNA on Sunday evening at 11 PM concerning the cold temperatures. The staff member addressed the issue beginning Monday 12/12/16 and work was started to repair the boiler for heat. The maintenance staff further revealed the 5 evaporative cooling units on the roof had not been covered for the winter to prevent cold air from coming into the building. i. Interview with the administrator on 12/15/16 at 12:34 PM verified there was not a planned	F 257		

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POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

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F 257	Continued From page 10 schedule for when the cooling system was to be winterized. j. Review of the maintenance "form of correction" dated 12/9/16 timed at 11:08 AM showed the maintenance staff arrived at 6 AM to the building and noted it was "cold in the facility due to -30 degrees[below zero] outside temperature." The note showed the thermostats were set at "75 degrees, and read 71 degrees." The temperature was adjusted up which resulted in an indoor temperature of 78 degrees F. Review of the 12/10/16 note timed at 8:20 AM showed the maintenance staff was called into work at 8 AM due to a heater leaking water in a resident room in the 600 hall. The note showed "...still cool temperatures in hall 600." The maintenance staff documented she contacted a plumbing company to address the issue. According to the note, an announcement was made over the intercom that heaters for halls 500 and 600 would be down. The note did not document what the temperature was in the facility. Review of the 12/11/16 timed at 8 AM maintenance note showed the maintenance staff was called into the facility at 7:53 AM due to a blown breaker. When she arrived she discovered standing water in the front 100 hall boiler room. The plumber was called and the "problem was fixed facility satisfied." There was no mention of the facility temperature on this note. Review of the 12/13/16 maintenance "form of correction" timed at 7:31 AM showed the maintenance staff was informed the 500 secured unit "was still remaining cold at night time." The note did not document any temperatures. The plumbers were called and the plumbing company's report showed there was heat to the 500 hall, "but both pumps in the boiler room on hall 600 are starting to show signs of stress." A bid to replace both pumps was being gotten, so	F 257		

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

PRINTED: 12/30/2016
FORM APPROVED
OMB NO. 0938-0391

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F 257	Continued From page 11 the pumps could be replaced as "soon as possible." k. Observation on 12/13/16 at 6:30 PM showed a company with temporary heaters had arrived at the facility. As of 12/15/16 at 8:45 AM the temperature on the thermostats showed the reading near room 509 was 75 degrees F, and the reading near the 600 hall exit was 76 degrees F.	F 257		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		
	483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:		**F-309: PROVIDE CARE SERVICES FOR THE HIGHEST WELL BEING** **Corrective Action** Resident #7 no longer resides in the facility. The heating issues in the facility have been resolved. **Identification of Others** The Director of Nursing or designee will identify residents with skin breakdown and moderate to high risk of skin breakdown. An audit will be completed on those residents to check care plan and kardex for interventions. The audit will also include observation that interventions are in place. Corrective action will be taken as needed.	1/24/17

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F 309	Continued From page 12 Based on observation, medical record review, and staff interview, the facility failed to ensure care and services were provided to maintain/attain the highest practicable physical well-being for 1 of 7 sample residents (#7). This failure resulted in a negative outcome for the resident who developed multi-location skin breakdown. The findings were: Review of the 10/25/16 annual MDS assessment showed resident #7 required extensive assistance for ADLs, and was at risk for pressure ulcers. Further review showed the resident did not have any pressure ulcers at the time of the assessment. Review of the pressure ulcer CAA showed chronic health conditions such as incontinence, inability to perform ADLs without significant physical assistance, existing pressure ulcer(s), and extrinsic risk factors (pressure) contributed to the problem. Review of the care plan related to skin issues showed it was initiated on 2/1/16. The resident had risk factors related to impaired mobility, incontinence, use of assistive devices (wheelchair), and a history of open areas. Interventions included an air mattress with an initiation date of 5/13/16. The following concerns were identified: a. Confidential interview with staff #1 on 12/14/16 revealed the 500 hallway where resident #7 lived was cold due to problems with the heat system. The staff stated the problem had been ongoing since Saturday 12/10/16, and the temperatures were so cold resident #7 was brought out of his/her room and into the main area to sleep on a mattress on the floor for 2 nights (12/10/16 and 12/11/16) and be warmed up. b. Confidential interview with staff #2 on 12/14/16 revealed residents on the secured unit	F 309	**Systemic Changes** The Staff Development Coordinator or designee will educate nursing staff on following interventions in care plans and kardex for actual or potential for skin breakdown. The education will also include: reporting environmental needs and uncomfortable temps to the maintenance staff with follow with NHA if needed, reporting immediately to Director of Nursing or designee if residents are affected by environmental factors, and if resident needs to be moved to an alternate area that care plan still needs to be followed and situation documented in medical record and nursing management should be consulted. **Monitoring** A random visual observation audit of residents twice per week on each shift will be conducted by the Director of Nursing or designee for ninety days to determine if care planned interventions for skin management are being followed. Corrective actions will be taken as needed for based on audit findings.	

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F 309	Continued From page 13 had been uncomfortable and complaining of the cold temperatures. The staff member reported the temperatures were uncomfortably cold on Friday 12/9/16, Saturday 12/10/16, and Sunday 12/11/16, and resident #7 was brought into the milieu to sleep on a mattress on the floor Saturday and Sunday due to the resident's room being so cold and the resident "freezing." c. Confidential interview with staff #3 on 12/14/16 revealed on the afternoon of 12/10/16, the resident was so cold in his/her room they were unable to get a temperature to register on the resident with a forehead temperature strip. She stated the resident was brought out of the room to be warmed up, and they placed the resident in a recliner and covered him/her with blankets. She further stated once the resident had warmed up a temperature was taken and she remembered it was about 95 degrees F. d. Review of the progress note dated 11/23/16 and timed at 2 AM showed the resident had an "open wound to lower spinal area approximately 1 cm circular over bony prominence" and the resident "...continues to be on an air mattress." Review of the progress note dated 12/6/16 and timed at 3:10 PM showed "area resolved 11/31." The next progress note was dated 12/11/16 at 2:44 PM and showed "Resident not eating or drinking well. Skin cool to touch. Warm blankets placed on resident to warm [him/her] SAO2 [oxygen saturation level] low? Accuracy d/t [due to] fingers cold, Resident noted with increased lethargy." Review of the SBAR (situational background assessment recommendation) note dated 12/12/16 at 7:33 PM showed the resident had developed "a new open area" on his/her buttocks. According to the 12/13/16 SBAR note, the open area to the coccyx/buttocks "...appeared to be a Kennedy	F 309	The Director of Nursing will track and trend the results of the plan audits and report to the QA Committee monthly. The committee will evaluate effectiveness of the plan until resolved.	

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F 309	Continued From page 14 ulcer [a type of ulcer associated with end of life] and has sdti's [suspected deep tissue injuries] to the back, scapula, bilateral feet, and a sheared blister to the right buttock, resident is declining in the last 48 hrs [hours]." There were no notes in the clinical record related to the resident sleeping on the mattress outside of his/her room, and no vital signs documented between 11/30/16 and 12/11/16. e. Review of the progress note dated 12/13/16 and timed at 10:37 AM showed the resident had "...Kennedy ulcer coccyx 8 x 7 iliac crest 1.5 x 3, lumbar spine 0.6 x 1, 1 x 0.4, 0.7 x 0.4, right scapula 0.4 x 1, left foot 1.5 x 1.8, right foot 2 x 2, left great toe 0.3 x 0.3. Multiple red areas that are blanching left second toe 0.5 x 0.7 left inner ankle 2 x 3, 2 x 2 left front ankle, medial left foot near arch 0.5 x 0.5, 1 x 1, right second toe 0.8 x 1.3, top of right foot 4.5 x 1, lateral right foot 1 x 0.7, scratch along right hip 3 x 0.2..." f. Interview with the DON on 12/15/16 at 10:25 AM verified the resident slept on a mattress on the floor for 2 nights. The DON stated he was not aware of this situation until 12/12/16. The resident's plan of care was not followed those 2 nights s/he was placed on the mattress outside of the room because the mattress was not an air mattress. The DON further verified information related to this situation was not documented in the clinical record and there was no other documentation related to the incident. g. Interview with the administrator on 12/15/16 at 11:21 AM verified he became aware of this situation on 12/12/16 when he arrived at the facility and saw the mattress on the floor in the secured unit milieu. He was concerned and stated the staff should have notified himself or the DON of the situation. He verified there was no documentation related to this instance. The	F 309		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 15 administrator stated the staff should have relocated the resident's entire bed, with the air mattress. h. Observation of the resident's skin on 12/15/16 at 11:42 AM with the medical director showed the resident had multiple closed wounds to the back, bilateral lower legs, bilateral feet, right hip, and a large open wound to the coccyx/buttock bilateral region.	F 309		
F 371 SS=E	483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		
	(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (l)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:		**F-371: FOOD PROCURE, STORE, PREPARE, SERVE-SANITARY** **Corrective Action:** The undated health shakes in the main kitchen refrigerator were removed and disposed of. The vents in the hood above the range/grill were replaced. The floor in the kitchen area was scrubbed and the outside of the two refrigerators were wiped clean. **Identification of Others:** The Dietary Manager and the Corporate Culinary/Nutritional Director conducted a check of the kitchen for areas of noncompliance and corrective action was done immediately.	1/24/17

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F 371	Continued From page 16 Based on observation and staff interview, the facility failed to ensure sanitary requirements were met related to dating of health shakes and cleanliness of equipment in 1 of 2 food storage/service areas (the main kitchen). The findings were: 1. Observation on 12/13/16 at 3:36 PM showed thawed health shakes were stored in a refrigerator unit in the main kitchen. There were more than 20 individual cartons of thawed shakes and the pan they were in showed a date of 12/9/16. Interview with the dietary manager and the corporate culinary/nutritional service staff member on 12/14/16 at 12:07 PM verified a system was needed to date mark the shakes so others knew when they were to be used by or discarded. According to the labels on the health shakes, they are to be used within 14 days of being thawed. 2. Observation on 12/13/16 at 3:46 PM and 12/14/16 at 11:25 AM showed the vents in the hood above the range/grill were rusted. There were 4 vents with visible rust located above this food preparation area. Interview with the dietary manager and the corporate culinary/nutritional service staff member on 12/14/16 at 12:07 PM verified the rusted vents needed to be replaced. 3. Observation on 12/13/16 at 3:46 PM and 12/14/16 at 11:25 AM showed the floor throughout the kitchen was soiled and sticky. Additionally, the outside of two refrigerator units around the handles were soiled with stuck-on food debris and grime. Interview with the dietary manager and the corporate culinary/nutritional service staff member on 12/14/16 at 12:07 PM verified the floors were scheduled to be mopped	F 371	**Systemic Changes:** A daily cleaning schedule has been developed to include the floors and refrigerator exterior and dietary staff has been educated on the process. Dietary staff has been educated on the procedure for dating the health shakes individually by the Dietary Manager. **Monitoring:** The Dietary Manager will monitor the cleaning schedule and check the refrigerator for unmarked or undated items 3 to 4 times per week. The Dietician or designee will do a kitchen inspection weekly for one month then twice per month until resolved. A report will be given at the QAPI meeting for review and corrective actions taken where necessary until resolved.	

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F 371	Continued From page 17 after each meal and the outside of equipment should be wiped down daily. At 4:10 PM the dietary manager and the corporate staff member stated additional accountability was needed to ensure the tasks were being completed on the cleaning schedule. According to Food Code 2013, U.S. Public Health Service: "4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	F 371		
F 465 SS=D	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a comfortable environment for staff in 3 random areas (the kitchen, the secured unit, the laundry room). The findings were:	F 465	**F-465: SAFE FUNCTIONAL SANITATARY COMFORTABLE ENVIRON.** **Corrective Action:** The boiler unit for the 500 hall has been repaired and the temperatures remain between 71 and 81 degrees. The open vent in the laundry room has been closed off. The swamp cooler above the kitchen has been covered to prevent cool air flow into the Kitchen/Dish area. The exterior door from the dry	1/24/17

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F 465	Continued From page 18 1. Observation on 12/14/16 at 12 PM showed the kitchen/dish room area felt cold. When the wall near the handwashing sink was measured with an infrared thermometer, the temperature measured 63.5 degrees F. The dietary manager stated a delivery was received at approximately 8 AM that morning and when the door was open it became more cold. There was also noticeable cold air coming in from the ceiling vents in the dish room and the dining room which was open to the kitchen. 2. Observation on 12/14/15 at 3:55 PM showed the laundry room felt cold. There were no staff working in the area at that time. However, there was a large ceiling vent which was uncovered and cold air from the outside came in. 3. Observation of the secured unit/500 hall on 12/13/16 at 2:50 PM showed the thermostat on the wall one near room 509 showed 65 degrees Fahrenheit (F) when observed at 2:50 PM. Interview with housekeeping staff at that time stated it was cold in the unit and had been over the weekend. Interview with staff member #3 on 12/14/16 verified the temperature in the secured unit had been cold for days due to problems with the boiler. 4. Interview with the maintenance staff member on 12/15/16 at 8:55 AM revealed she was the only maintenance staff member since the maintenance director's last day on 12/5/16. The staff member verified the boiler in the back area had gone down over the weekend. The staff member addressed the issue beginning Monday 12/12/16 and work was started to repair the boiler for heat. The maintenance staff further revealed	F 465	storage room has been repaired/replaced to prevent cold outer air from drafting in. The open vent in the laundry room has been covered. The vents in the Main Dining room have been covered. **Identification of Others:** The Maintenance Director has done a facility walk through to determine if there were any areas that have drafts or are below 71 degrees. Areas that fall below that temperature or have a cold draft have been resolved. **Systemic Changes:** Maintenance or designee will check the temperatures twice per day to ensure temperatures are maintained between 71 and 81 degrees. Variances to these temperatures will be acted on immediately. Staff was educated on the need to notify the Administrator and/or Maintenance if the facility feels cold or the thermostat reads below 71 degrees.	

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F 465	Continued From page 19 the 5 evaporative cooling units on the roof had not been covered to prevent cold air from coming into the building. 5. Interview with the administrator on 12/15/16 at 12:34 PM verified there was not a scheduled plan for when the cooling system was to be winterized.	F 465	A protocol was put in place and staff educated on what to do if the facility temperature reaches 70 degrees or below. **Monitoring:** Results of the temperature checks will be presented to the Monthly QAPI meeting for review and corrective actions if necessary.	