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

PRINTED: 02/24/2017
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 _____	02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	430A 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 A recertification survey was conducted by Healthcare Licensing and Surveys on 2/6/17 through 2/8/17. Also reviewed in the course of the survey was complaint intakes #WY00002336, #WY00002337, WY00002338, WY00002348, and WY00002353. The following common abbreviations are used throughout the document: ADLs Activities of Daily Living BIMS Brief Interview for Mental Status CNA Certified Nurse Aide DON Director of Nursing IOP Infection Control Preceptioner LPN Licensed Practical Nurse MDS Minimum Data Set RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 226 SS=E	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 misappropriation of their property; or	F 226	Poplar F225 PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN	4/10/17

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

4/10/2017

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

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F 225	Continued From page 1 (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, exploitation, or mistreatment while the	F 225	**ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** The identified certified nursing assistants #11, #12, #13, #14 and #15 have had employment screening completed per regulatory requirements. Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 and Scheduler #1 have also had their employment screening per regulatory requirement. The community has completed State nurse aide registry checks on the identified certified nursing assistants and a copy of this check has been placed in their employee file. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Other residents residing in the community have the potential to be affected by this deficient practice. The community has completed an audit of other certified nursing assistants files to	

4/11/17 – This POC accepted [illegible]

[illegible]

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F 225	Continued From page 2 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 review of employee files and policies and procedures and staff interview, the facility failed to ensure pre-hire screenings for abuse/neglect findings were completed prior to resident contact for 8 of 16 sample employees (CNAs #11, #12, #13, #14, and #15, RN #1, LPN #1, scheduler #1). In addition, the facility failed to ensure the State nurse aide abuse registry was checked prior to resident contact for 5 of 5 sample CNAs (#11, #12, #13, #14, #15) reviewed. The findings were: 1. Employee files for 16 sample employees were reviewed with the unit assistant on 2/9/17 at 3:10 PM. This review revealed the facility received background check information for 8 of the 16 employees after they had resident contact. The following concerns were identified: a. CNA #11 was hired on 10/5/16; and results were received on 10/17/16 (12 days). The CNA's first day of resident contact was 10/7/16. b. CNA #12 was hired on 11/8/16; and results were received on 11/10/16 (2 days). The CNA's first day of resident contact was 11/9/16. c. RN #2 was hired on 10/5/16; and results were received on 10/27/16 (22 days). The RN's first day of resident contact was 10/16/16. d. CNA #13 was hired on 12/1/16; and	F 225	ensure compliance is achieved with regulatory requirements; specifically, the certified nursing assistants have employment screens completed and evidence of registry checks in their employment file. All other licensed staff have been audited to ensure their employment screening has been completed per regulatory requirements. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The Consultants provided re-education and training to the Interdisciplinary Team (IDT) on the regulatory requirements regarding pre-employment screening as well as checking the state nurse aide prior to resident contact. The community Staff Engagement Coordinator (SEC) will be responsible to complete new employee registry screens and nurse aide registry checks. The Consultant implemented a new form titled "NHA New Hire File Sign Off" that will need to be completed and signed off by the NHA or designee before any newly hired staff member can engage in resident contact / complete a shift in the community. The NHA or designee will be responsible to ensure overall compliance.	

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F 225	Continued From page 3 results were received on 12/8/16 (7 days). The CNA's first day of resident contact was 12/2/16. e. LPN #1 was hired on 12/1/16; and results were received on 12/5/16 (4 days). The LPN's first day of resident contact was 12/2/16. f. Scheduler #1 was hired on 12/1/16; and results were received on 12/8/16 (6 days). The Scheduler's first day of resident contact was 12/2/16. g. CNA #14 was hired on 11/21/16; and results were received on 11/23/16 (2 days). The CNA's first day of resident contact was 11/21/16. h. CNA #15 was hired on 12/22/16; and results were received on 1/3/17 (12 days). The CNA's first day of resident contact was 12/26/16. 2. Review of the employee files for CNAs #11, #12, #13, #14, and #15 revealed verification from the State nurse aide registry had been received for the 5 CNAs, and none had abuse/neglect findings. However, this review also revealed the facility did not receive the verifications until after the CNAs had resident contact. The following concerns were identified: a. CNA #11 was hired on 10/5/16; and verification was received on 10/17/16 (12 days). b. CNA #12 was hired on 11/8/16; and verification was received on 11/10/16 (2 days). c. CNA #13 was hired on 12/1/16; and verification was received on 12/8/16 (7 days). d. CNA #14 was hired on 11/21/16; and verification was received on 11/23/16 (2 days). e. CNA #15 was hired on 12/22/16; and verification was received on 1/3/17 (12 days). 3. Interview with the unit assistant during review of the employee files on 2/9/17 at 3:10 PM revealed she recently became responsible for ensuring all pre-hire requirements were met; and	F 225	**IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The NHA will be responsible to report to the QAPI Committee on a monthly basis a review of any concerns with completion of the "NHA New Hire File Sign Off. The NHA or designee will be responsible to follow up on any recommendations made by the QAPI committee.	

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F 225	Continued From page 4 she had not learned all this responsibility entailed. At that time she acknowledged the delayed confirmations and/or verifications allowed individuals to have resident contact before the facility received information about any past involvements with elder abuse and neglect. 4. Interview with the DON on 2/23/16 at 4:10 PM revealed new employees complete orientation and are then scheduled to work on the unit, usually with another staff person initially. 5. Review of the policy and procedure titled, "Abuse and Neglect Prohibition", revised February 2017, showed, "The facility does not hire or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property in a court of law" and "The facility does not hire or otherwise engage individuals who have findings on the State Nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property."	F 225		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, medical record review, and staff interview, the facility failed to ensure care and treatment was	F 241	Poplar F241 **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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**	4/10/17

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F 241	Continued From page 5 provided in a manner that promoted quality of life and dignity for 4 of 21 sample residents (#35, #72, #75 #78). The findings were: 1. Observation on 2/8/17 at 1 PM showed resident #72 was awaiting a trip to the store. S/he appeared happy and said the plan was to get treats/gifts for the upcoming holiday. Interview on 2/8/17 at 5:58 PM with the resident revealed the outing to the store was canceled at the last minute. The resident did not know why the outing was canceled and stated this was the third time in a row the shopping trip had been canceled and the staff had not provided a reason. The resident stated this made him/her feel "lousy" because "Valentine's day is next week and I won't have anything." Interview with the activity director on 2/9/17 at 2:58 PM verified the shopping trip was canceled the day before due to limited availability of the van. She verified this was the third time in a row the trip was canceled; once was due to weather and twice to the availability of transportation. She was aware the residents who had planned to go were unhappy, and she said the cancellation was decided last minute. She stated she'd try to re-schedule the trip or get to the store with lists to purchase items for them; however, she was unsure if it would be before the holiday on 2/14/17. 2. Interview on 2/8/17 at 10:29 AM with resident #78 revealed the staff were slow to respond to his/her requests such as getting up into the chair. The resident stated "last night between 9 PM and 12 PM" s/he called to have assistance to reposition in bed, his/her feet were hanging over the end of the bed. The aide who answered the call told the resident she could not help him/her. The aide told the resident a second person would	F 241	**CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** The Community policy was reviewed and updated to include the procedure for unexpected cancellations and the expectations for rescheduling. This information was presented to an ad hoc resident council meeting on 4/4/17 where resident input was requested and included in the current policy dated 4/5/2017. The Consultants completed	

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F 241	Continued From page 6 be needed and there was no one else who could help her, s/he would have to "do it [herself/himself]." The resident stated s/he's "treated poorly." The resident revealed another time when s/he asked an aide to transfer him/her from bed to the recliner to sleep due to discomfort, the resident was told "the nurse says no, you do not need to do that." The resident was not sure of the date this occurred, appeared frustrated, and then said, "I'm my own person." According to the resident, s/he was not transferred to the recliner and had to wait for another aide, who assisted with the transfer. Review of the 11/30/16 quarterly MDS assessment showed the resident was cognitively intact with a BIMS score of 13. 3. On 2/8/17 from 5:06 PM to 6:35 PM interviews were conducted individually with 11 staff members. Seven of the 11 staff members stated there were shortages of nurses and CNAs. Staff member #1 stated they have to "rush" and "can't give residents the time they want" and the residents tell her she "works too hard." Staff member #3 stated "we're doing the best we can" and the "residents are missing extra conversation." Staff member #6 stated they have to rely on finding managers, nurses and others who can help if they need 2 people to assist a resident. The managers are not available on the weekends so this becomes harder. She stated "residents say it's hard to get their medications on time." Staff member #7 stated the nurses are "overwhelmed." Staff member #8 stated on the day shift they were down 1 nurse and 1 aide and it gets "a little rough." They're trying hard and they're "often a little late on medications." Staff member #9 revealed the inadequate staffing situation was "frustrating" and it "upsets the	F 241	Abaqis Interviews on the four (4) residents identified in the original deficiency list with their concerns/compliments generating complaint/concern documentation, follow up, and action plans as indicated. Included in the agenda at the Resident Council Meeting was the community procedure for grievances and the contact information if a resident/family would like some additional support with his/her concerns. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Other Residents within the community have the potential to be affected by this alleged deficient practice. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The Resident Council Meeting Agenda Template was updated to include current complaint/concerns/compliments as well as review of those identified in previous meeting. This agenda will also include a Resident Right of the Month for review	

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F 241	Continued From page 7 residents because they don't get the time and attention they need." Staff member #10 revealed the facility was "short staffed most of the time and nights are the worst." In addition, she stated "It [care] takes longer than what [the residents] want." and "there is very little help from nurses or administration on this shift." 4. Interview on 2/7/17 at 10 AM with a group of 10 residents revealed they did not feel the staff treated them with respect and dignity. All residents present agreed "they treat us like children" and "they control everything." In addition, the residents referenced the saying on the wall in the entryway as "hypocritical." The saying read as follows: "The residents do not live in our work place we work in their home." 5. Observation on 2/6/17 at 2:58 PM showed resident #35 was outside in the hallway near his room. The resident stated his razor had been taken and one was needed so he could shave. The maintenance director was passing and stopped and stated she would pass on the information regarding the razor and shaving. Observation on 2/7/17 at 8:50 AM showed the resident remained unshaven. Interview with the resident at that time revealed he didn't need assistance with shaving, he just needed a razor. Interview with bathaide #1 on 2/7/17 at 9:07 AM and bathaide #2 on 2/7/17 at 9:24 AM revealed there was one electric razor that was used for the men who didn't have their own. They had not been made aware that this resident was requesting a shave. Interview with the maintenance director on 2/8/17 at 10:28 AM verified she had not passed on the information knowing the resident would receive a shave when next provided a shower. She further stated the	F 241	and conversation. Beginning with Quarterly Care Conferences scheduled the week of April 17th, Abaqis Surveys will be conducted with each interviewable resident on a quarterly or as indicated basis. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The Customer Service Director or designee will be responsible to report to the QAPI Committee on a monthly basis a summary of Complaints/Concerns/Compliments generated from Resident Council Meetings, this report will identify those reported concerns that have not been resolved. The Customer Service Director or designee will be responsible to follow up on any recommendations made by the QAPI committee. The Customer Service Director or designee will be responsible to report to the QAPI Committee on a monthly basis a summary of Complaints/Concerns/Compliments generated from QIS interviews, this report will identify those reported	

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F 241	Continued From page 8 resident was not safe to use a blade razor. Review of the 12/22/16 quarterly MDS assessment showed the resident required supervision and one person physical assistance with personal hygiene.	F 241	concerns that have not been resolved. The Customer Service Director or designee will be responsible to follow up on any recommendations made by the QAPI committee.	
F 253 SS=E	483.10(l)(2) HOUSEKEEPING & MAINTENANCE SERVICES (l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 3 of 6 resident hallways (200, 500, 600) were clean and in good repair. The findings were: 1. Observation on 2/9/17 at 8:10 AM in the 600 hallway revealed the following issues: a. The caulk around the base of the toilet in room #608 was damaged and yellow-stained. b. The air vent cover on the ceiling of room #609 was partially blocked with uneven duct tape that collected dust. c. The 600 hallway shower room had a 4-inch by 4-inch missing tile near the floor to the left of the shower, and the wall area was dirty. 2. Observation on 2/9/17 at 8:30 AM in the 500 hallway revealed the following issues: a. The caulk around the base of the toilet in room #503 was damaged and yellow-stained. b. The caulk around the base of the toilet in room #504 was damaged and yellow-stained. c. The caulk around the base of the toilet in room #505 was damaged and yellow-stained. d. The caulk around the base of the toilet in	F 253	**Poplar F253** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.**	4/10/17

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F 253	Continued From page 9 room #510 was damaged and yellow-stained. e. The closet door in room #510 had a 5-inch by 2-inch hole at 2 inches above the floor. f. The caulk around the base of the toilet in room #509 was damaged and yellow-stained. Also, the left wall above the heat vent cover in the bathroom had a 7-inch long by 2-inch wide scrape. 3. Observation on 2/9/17 at 8:45 AM in the 200 hallway revealed the following issues: a. The back of the 200 shower room door had a damaged and loose kick plate at the top left that was 3.5 inches across. 4. Observation and interview on 2/9/17 at 9:30 AM with the maintenance director confirmed these issues. She had identified the issues prior to the tour and had documented them. However, the facility failed to have a timeframe for those repairs.	F 253	**I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** The caulk around the base of the toilet in rooms #608. #503, #504, #505, #509, and #510 has been repaired or replaced. The air vent cover on the ceiling of room #609 has had the duct tape removed. The 600 Hallway shower room has had the missing tile repaired. The hole in room #510's closet has been repaired. The heat vent covers in the bathroom of room #500 that had a scrape has been repaired. The shower room door kick plate was repaired.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278	**II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Other residents residing in the community have the potential to be affected by this deficient practice. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The community will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The community has implemented a morning QAPI stand up meeting and an afternoon	

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F 278	Continued From page 10 that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure MDS assessments were accurately completed for 6 of 21 sample residents (#18, #42, #73, #74, #79, #89, #100, #105) reviewed. The findings were: 1. Review of the 12/5/16 quarterly MDS assessment for resident #42 revealed an admission date of 8/29/16. Section O250 showed the influenza vaccination was coded as "not given" and "resident did not reside in the facility during the current year's influenza vaccination season." Review of the facility influenza log sheet revealed the resident received his/her vaccine on 10/14/16. 2. Review of the 11/15/16 admission MDS assessment and the 1/17/17 quarterly MDS	F 278	follow up meeting. The facility has adopted a new 24 hour report which is reviewed every morning (Monday through Friday) by the Interdisciplinary team and is reviewed by managers on the weekend. Additionally, the community has adopted a new morning briefing agenda which minimally covers the following survey related topics to include: nursing concerns, housekeeping/laundry concerns, maintenance concerns, social service follow up issues, and MDS issues. Lastly, the IDT team reviews any survey plan of correction follow up required. The community reconvenes at 3:30 P.M. daily to ensure any follow up items identified during morning QAPI meeting have been corrected. The Maintenance Director or Designee to complete weekly rounds utilizing an Environmental Round Audit tool for 3 months to ensure these areas of concern remain addressed. The Consultant provided education and training with the NHA/Maintenance Director on 4/4/2017 regarding expectations of keeping a clean environment that is homelike. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The Maintenance Director or Designee will be responsible to report on the	

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F 278	Continued From page 11 assessment for resident #73 showed inaccuracies in the following areas: a. Review of section O250 of both assessments showed the influenza vaccination was coded as "not given" and "not offered." Review of the facility influenza log sheet revealed the resident received his/her vaccine in a physician's office. However, the date given was not documented. b. Review of the admission MDS assessment showed section K200 for weight and height was left blank and the quarterly MDS assessment section K200 for height was left blank. c. Review of the quarterly MDS assessment showed the Pain Management section J200 (Pain Presence), "Should Pain Assessment Interview be Conducted?" was coded as 1 (yes) and section J300 (Pain Frequency) was coded as 9 (unable to answer). Review of the medical record showed a pain evaluation had been completed with the resident. 3. Review of the 12/2/16 admission MDS assessment and the 1/10/17 significant change MDS assessment for resident #74 showed inaccuracies in the following areas: a. Review of section O250 showed the influenza vaccination was coded as "not given" and "resident not in this facility during this year's influenza vaccination season." Review of the facility influenza log sheet showed no documentation related to the resident. Interview with the ICP on 2/9/17 at 3 PM revealed the resident had received his/her vaccination from an outside source, but it had not been documented. b. Review of the significant change MDS assessment showed section K200 for weight was left blank and section K310 for weight gain was marked as "no or unknown". Review of the	F 278	Environmental Round Audits to the QAPI Committee monthly until a lesser frequency is determined appropriate. The Maintenance Director or designee will be responsible to follow up on any recommendations. **Poplar F278** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A**	3/10/17

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F 278	Continued From page 12 medical record showed a weight of 152.6 pounds was documented on 1/9/17 which revealed a weight gain of 11.8% since the admission MDS assessment. c. Review of the significant change MDS assessment showed the resident received scheduled and PRN (as needed) pain medication. Section J200 was coded as 0 (resident is rarely/never understood) and section J800 (staff assessment for pain) was completed and coded as "Z" (none of these signs observed or documented). Review of the medical record showed a pain evaluation had been completed with the resident. d. Review of the admission MDS assessment and the medical record showed two different date of birth. The admission MDS assessment showed a birth month of May. The medical record and significant change MDS assessment showed a birth month of February. 4. Medical record review showed resident #79 had diagnoses which included malnutrition, gout, and type II diabetes. Review of the 9/9/16 annual MDS assessment, the 9/30/15 annual MDS assessment, and the 1/3/17 quarterly MDS assessment for the resident showed section K200 for weight was left blank. Review of the medical record showed the resident was weighed monthly and the weights were recorded. Interview with the MDS coordinator on 2/9/17 at 2 PM confirmed the area for weight on the MDS assessments was left blank for resident #79. 5. Review of the 12/29/16 quarterly MDS assessment for resident #89 showed inaccuracies in the following areas: a. Review of section O250 showed the influenza vaccination was given on 11/15/15.	F 278	**OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** The MDS assessment for resident #42 has been updated to reflect accurate influenza vaccination status. Resident # 73 has had their MDS Assessment updated to accurately reflect sections J200 and J300 to accurately reflect resident's status. Resident #73 now has weight recorded on the most current MDS and height will be captured on the next quarterly assessment. Resident #74 has had their MDS Assessment updated to reflect accurate influenza vaccination status. Sections K200 and K310 have been updated to accurately reflect weight status, Sections J200 and J800 have been updated to accurately reflect pain status. The MDS assessment and the medical record have been updated to reflect the resident's proper birth date. Resident #79 has had the MDS assessment has been updated to reflect his current status. Resident # 100 has had Section O250 updated to accurately reflect Influenza vaccination status. Resident #18 has had Section J0200, J0800 and K0200 updated to more accurately reflect pain status. The height and weight will be recorded on the next quarterly MDS. Resident #105 has had the MDS assessment updated to accurately reflect	

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F 278	Continued From page 13 Review of the facility influenza log sheet showed the vaccination was administered on 10/16/16. b. Review of section J100 showed the resident had not received any scheduled pain medication in the past 5 days. Review of the December 2016 MAR (medication administration record) showed Norco (pain killer) 5-325mg (milligrams) was administered at bedtime on 12/24, 12/25, 12/26, 12/27, 12/28, and 12/29. c. Section J200 was coded as 0 (resident is rarely/never understood) and section J600 (staff assessment for pain) was completed and coded as "Z" (None of these signs observed or documented). Review of the medical record showed a pain evaluation had been completed with the resident. 6. Review of the 11/18/16 quarterly MDS assessment for resident #100 revealed the following inaccuracy; Section O250 showed the influenza vaccination was coded as "not given" and "resident did not reside in the facility during the current year's influenza vaccination season." Review of the facility influenza log sheet revealed the resident received his/her vaccine on 10/19/16. 7. Review of the 12/18/16 admission MDS assessment showed resident #18 was marked yes at J0200 to have a pain assessment interview conducted. The resident had a BIMS score of 14 and was cognitively intact. The remainder of the resident pain interview was not completed, rather the staff assessment for pain at J0600 was completed. In addition, section K0200, the area for height and weight were left blank. 8. Interview with the MDS coordinator on 2/9/17 at 1:47 PM verified the inaccuracies on these MDS assessments including the pain	F 278	pressure ulcer status. Resident #89 has had Section O250 updated to accurately reflect Influenza vaccination status. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** All other residents in the community have the potential to be affected by this deficient practice. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The MDS Coordinator is responsible to complete the MDS. The Consultant provided re education and training with the MDS Coordinators on 4/4/17 on the expectations for accurate and complete assessments per regulatory requirements. The DON or designee will review 4 MDS's weekly for compliance and accuracy and make any changes necessary to correctly reflect their current status. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The MDS Coordinator or Designee will be responsible to report on the MDS audits to the QAPI Committee monthly until a lesser frequency is determined	

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F 278	Continued From page 14 assessments. She further stated the data for the height and weight sections was lacking. 9. Review of the 8/3/16 significant change MDS assessment showed resident #105 had an unstageable pressure ulcer. Review of the pressure ulcer treatment and monitoring records showed staff implemented ongoing treatment and monitoring for his/her pressure ulcers from August 2016 to December 2016. However, review of the 11/28/16 significant change MDS assessment showed the resident did not have pressure ulcers. Interview with the MDS coordinator on 2/9/17 at 2:10 PM revealed the 11/28/16 MDS assessment was not accurate because the resident had pressure ulcers at that time.	F 278	appropriate. The MDS Coordinator or designee will be responsible to follow up on any recommendations.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental	F 279	**Poplar F279** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS**	4/18/17

4/18/17

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F 279	Continued From page 15 and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (II) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(8). (III) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 279	**OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Resident #19 has had their Care Plan updated to address interventions needed if resident repeats the inappropriate behavior of visiting resident #75 and other residents against their wishes. Resident #85 has had their Care Plan updated to address interventions to ensure for all residents and staff safety if resident repeated inappropriate behavior. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** All other residents in the community have the potential to be affected. A whole house audit was completed. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:**	

4/11/17

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F 279	Continued From page 16 section. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and incident review, the facility failed to ensure a comprehensive care plan was developed based on resident needs for 2 of 26 sample residents (#19, #85). The findings were: 1. Medical record review showed resident #19 had diagnoses which included depressive disorder, cirrhosis of the liver, unspecified psychosis not due to a substance or known physiological condition, and alcohol abuse. The review showed the resident was independent with ambulation. Review of a 1/23/17 incident revealed the following: "Resident drunk, went into the room of [resident #75] [his/her] on again/off again [romantic interest] and was asked to leave, left, police called due to [resident #19's] behaviors." Review of a 1/23/17 SBAR (Communication Form and Progress Note) concerning the 1/23/17 incident revealed the following: "Resident found in resident #75's room standing over resident #75's bed attempting to kiss resident, this resident was asked to leave resident #75's room, resident #75 was visibly upset and stated [s/he] did not want resident #19 in [his/her] room and has asked [him/her] multiple times not to come in there." Interview with resident #75 on 2/9/17 at 11 AM confirmed the incident. Resident #75 stated that resident #19 was persistent and kissed resident #75 and kept repeatedly attempting to kiss him/her, though resident #19 was told repeatedly by resident #75 and staff to stop; and that is why the local police were called. Resident #75 stated s/he was not afraid of resident #19, but would call law enforcement if resident #19 came into his/her room again. The following care plan concerns	F 279	The community IDT will continue to review all residents care plans on an ongoing quarterly basis to ensure all pertinent problems are captured on residents plans of care to ensure the are individualized, complete and accurate. The community IDT team will review at least four (4) residents care plans weekly to ensure the plan accurately reflects residents current status. On 4/4/2017 the IDT team was re-inserviced by the Consultants on the importance of having correct and appropriate care plan for each resident. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The Social Services Director or Designee will be responsible to report on the care plan audits to the QAPI Committee monthly until a lesser frequency is determined appropriate. The Social Services Director or Designee will be responsible to follow up on any recommendations.	

4/11/17

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F 279	Continued From page 17 were identified: a. Review of the care plan for resident #19 showed the following "Focus"; "[Resident #19] has a behavior problem of drinking alcohol unsupervised. [S/he] likes to go see a [fe/male] friend to tell [him/her] goodnight after [s/he] is already gone to bed and does not want to be bothered. [Resident #19] has a history of drinking alcohol." The following interventions were documented: "Administer medications as ordered, Observe/document for side effects and effectiveness. Encourage [resident #19] to speak to a counselor about [his/her] drinking alcohol. Praise any progress/improvement in behavior. Remind [resident #19] that after [his/her] friend is in bed [s/he] would have to wait until the morning to talk with [him/her] per [his/her] request." The plan failed to address what interventions staff were required to implement if the resident repeats the inappropriate behavior in order to ensure resident and staff safety. b. Interview with the MDS coordinator on 2/9/17 at 2 PM confirmed the facility failed to ensure an adequate plan of care to address resident #19's inappropriate behavior toward other residents. 2. Medical record review showed resident #85 had diagnoses which included adjustment disorder with depressed mood and alcohol abuse. The review showed the resident self-propelled via wheelchair and was being fitted with a prosthesis for future gait training. Review of 2 separate incident reports dated 2/7/17 revealed the following: For the 8:05 PM incident report findings, "Resident angry at staff for not allowing [him/her] to enter [fe/male] resident's room when informed [s/he] did not want [him/her] in there. Began yelling that [s/he] had rights to go and do	F 279		

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F 279	Continued From page 18 whatever [s/he] wanted. Staff refused to debate, [resident] became angrier and threatening, asked to go to room and complied." For the 8:40 PM incident report findings, "Resident approached nurse, threatening to get nurse fired, had videos to get nurse arrested, nurse refused to engage, informed that police would be called if behavior continues, became angrier, police called, resident attempted to involve others, sat at end of hall and yelled insults at nurse." Review of the corresponding incident report conclusion summary (for both incidents) revealed the following, "[Resident #85] did go into [resident #23's] room according to [resident #23], [his/her] roommate, and nursing staff. [Resident #23] reports that [s/he] told [resident #85] to leave [his/her] room since [s/he] was in bed and did not want to have any visitors. [Resident #85] finally left [his/her] room but then proceeded to come back to the room after seeing the nursing staff about something [resident #23] needed. Nursing reported that [resident #85] had an alcohol smell which corresponds to [his/her] witnessed behaviors of being loud and verbally abusive toward nursing staff. It appears that [resident #85's] perception of the situation is much different than nursing staff, resident witnesses, and [resident #23's] report. [Resident #85] may believe [s/he] left the situation with no issues however staff and other residents report that [s/he] was verbally abusive to nursing staff and reluctant to leave [resident #23's] room. [Resident #85] has been educated that [s/he] cannot go into another resident's room if [s/he] is not invited or when they do not want [him/her] there. Police were contacted and spoke to [resident #85] about staying around [his/her] room area late at night." The intervention for resident #85 was: "[Resident #85] agreed to see a counselor about possible	F 279		

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F 279	Continued From page 19 behavior modification with [his/her] alcohol issues since it appears [s/he] has trouble with perceptions of issues that happen in relation to drinking alcohol." The following care plan concerns were identified: a. Review of the care plan showed the following under "Focus": "[Resident #85] has a behavior problem of hiding alcohol in [his/her] room and a history of drinking. When the alcohol is removed [s/he] makes allegations of missing money. [Resident #85] has a behavior problem of going into another person's room late at night even when staff and other residents tell [him/her] not to." The following interventions were documented: "Administer medications as ordered. Observe/document for side effects and effectiveness. Encourage [resident #85] to continue counseling for behavior modification. Notify MD if needed. Praise any indication of the resident's progress/improvement in behavior. Remind [resident #85] that [s/he] cannot go into another person's room unless [s/he] is invited." The plan failed to address what interventions staff were required to implement to ensure resident and staff safety if the resident repeated the inappropriate behavior. b. Interview with the MDS coordinator on 2/9/17 at 2 PM confirmed the facility failed to ensure an adequate plan of care to address resident #85's inappropriate behavior toward other residents.	F 279	**Poplar F281** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.**	4/10/17
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281	**I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Resident #25 has had the physician and resident representative notified of the medication	

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F 281	Continued From page 20 must- (I) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, professional standard review, and medical record review, the facility failed to ensure nursing standards of practice were followed regarding medication administration and documentation for 3 of 21 sample residents (#25, #72, #100) and 1 non-sample resident (#4). This failure was evidenced by 1 resident (#25) who did not receive medications as prescribed by the physician and 3 residents (#4, #72, #100) who did not receive medications within an acceptable timeframe. The findings were: 1. Review of the medical record showed resident #25 had diagnoses that included chronic pain, diabetes, seizure disorder, and anxiety. Review of the February 2017 MAR showed on 2/1/17 four routinely scheduled medications were not documented as having been administered. These included Baclophen 5 mg tablet to be given 3 times per day for pain; Keppra 500 mg 2 times per day related to unspecified convulsions; Metformin HCL tablet 500 mg 2 times per day for type 2 diabetes; and Mirtazapine 7.5 mg tablet once per day for anxiety. Further review of the MAR showed there was no explanation as to why these medications were not administered or any rationale for why the MAR was left blank. Interview with the DON on 2/9/17 at 8:55 AM verified there was no information related to the lack of medication administration documentation on the MAR for these medications on this day. 2. Review of the February 2017 medication	F 281	omissions. Resident #4 has been notified of the medication error as well as the physician and resident representative. Resident #72, physician and resident representative have been notified of the medication administration delay. Resident #100, the physician and resident representative have been notified of the medication administration delay. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Other Residents receiving medications have the potential to be affected by this deficient practice. The community nursing staff have been re educated on the community Medication Administration Policy and Procedure as well as the importance of medication administration in accordance with physician orders. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The nursing staff have received re-education and training on the importance of timely medication administration. The nursing staff were educated to report any concerns with medication administration to the DON for review	

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F 281	Continued From page 21 administration details summary report for resident #4 showed the resident was scheduled to receive Lasix 60 mg at 6 AM and 12 noon every day. Further review showed the resident did not receive the 6 AM dose on 12/9/17, but received the first dose of the day at 1:34 PM (this exceeded the time for both scheduled doses). Review of the medical record and the February 2017 medication administration details summary report on 2/9/17 at 5:09 PM revealed the 6 AM dose was not available and there was no documentation regarding the rationale for the delayed dose at 1:34 PM. 3. Interview with resident #72 on 2/7/17 at 10:40 AM revealed his/her symptoms were worse when the medication for Parkinson's disease (Sinemet) was not administered at approximately the same time each day. Review of the February 2017 medication administration details summary report showed scheduled doses of Sinemet were to be administered 4 times daily. Further review revealed from 2/4/17 to 2/8/17, 6 doses were administered 1 hour and 30 minutes to 3 hours past the scheduled administration time. Review of the medical record showed no documentation regarding the rationale for the delayed doses. 4. Review of the 11/28/16 quarterly MDS assessment for resident #100 showed diagnoses that included Parkinson's disease and GERD (gastroesophageal reflex disease). The following concerns were identified: a. Observation on 2/8/17 at 11:35 AM showed the resident was in the dining room for the lunch meal. The resident stated "I don't feel good" and pushed away from the table. The resident was taken out of the dining room to RN #1. The resident told the RN s/he felt "nauseated." The	F 281	and follow up. The DON or designee completed Medication Administration Record Audits (MAR) to ensure residents are receiving medications as prescribed by their primary care physician. Additionally, the DON or designee will complete weekly audits of MAR to ensure medications are being administered as prescribed. If concerns are identified, the DON or designee will be in charge notifying appropriate parties. The DON or designee will be responsible to report findings of the audits to the QAPI Committee. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The DON or Designee will be responsible to report MAR audits to the QAPI Committee monthly until a lesser frequency is determined appropriate. The MDS DON or Designee will be responsible to follow up on any recommendations.	

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F 281	Continued From page 22 RN stated she had not had a chance to administer the resident's morning medications. The medications, Sinemet and Nexium, were administered at 11:44 AM and the resident was taken to his/her room to lay down. Review of the February 2017 MAR showed these medications were scheduled to be given at 9 AM. b. Review of the February MAR showed Nexium (medication to treat GERD) 40 mg was to be administered daily at 9 AM. Review of the "Administration Details Summary" for dates between 1/25/17 and 2/8/17 (15 days) showed 8 of the 15 scheduled doses of the medication were administered outside of the acceptable variance of 1 hour before or after the scheduled administration time; the longest being approximately 5 hours and 20 minutes on 1/25/17. All of the entries were coded as "0" (administered) with no documentation in regard to what caused the delay. c. Review of the February MAR (medication administration record) showed Sinemet (medication to treat Parkinson's disease) 25-100 mg (milligrams) was to be administered by mouth twice a day at 9 AM and 5 PM. Review of the "Administration Details Summary" for dates between 1/29/17 and 2/8/17 (11 days) showed 7 of the 22 scheduled doses of the medication were administered outside of the acceptable variance of 1 hour before or after the scheduled administration time; the longest being 2 hours and 45 minutes on 2/8/17. All of the entries were coded as "0" (administered) without a documented cause of the delay. d. According to Villerand, A.H. (2015). Davis's Drug Guide for Nurses (14th ed.). Philadelphia, PA; F.A. Davis Company, Sinemet should be administered on a regular schedule.	F 281		

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F 281	Continued From page 23 5. Interview with the DON on 2/9/17 at 9 AM revealed nurses were required to administer medications as prescribed and within an hour of the scheduled time, use the electronic chart codes, and document the reason medications were not given as ordered. At that time, the DON reviewed the medication administration detail summary forms with the surveyor, and stated some of the documented inaccuracies were due to staff failure to make additions and revisions after their initial database entry. He further stated the facility was in the process of developing staff education to address the concerns identified in the above examples. 6. Review of "Kozier and Erb's Fundamentals of Nursing Concepts, Process, and Practice," 10th Edition, 2016, by Berman, Snyder and Frandsen showed the following standards of nursing practice: a. In Unit 4, section titled, "Carrying Out a Physician's Orders," page 68: " Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider... If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out." b. In Unit 8, Chapter 35 titled, "Medications," page 773: "If a medication is not given, follow the agency's policy for documenting the reason why." c. In Unit 8, Chapter 35 titled, "Medications," page 778: "If medication was refused or omitted, record this fact on the appropriate record; document the reason, when possible, and the nurse's actions according to agency policy."	F 281	**Poplar F282** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Resident #76 continues to utilize an air mattress and this intervention is identified on the plan of care.	4/10/17
F 282	483.21(b)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 24 PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, and staff interview, the facility failed to ensure the care plan was followed for 1 of 26 sample residents (#76). The findings were: Review of the 11/30/16 quarterly MDS assessment showed resident #76 was cognitively intact with a BIMS score of 13 and was at risk for developing pressure ulcers. Review of the care plan related to potential/actual skin issues showed it was initiated and revised on 8/29/16. The interventions for this problem area included an "air mattress." The revision shown for this intervention was dated 1/20/17. Interview with the resident on 2/8/17 at 10:40 AM revealed the mattress on his/her bed was not comfortable and a new one was expected; however, it was taking a "long time." S/he further revealed since being in the facility there had been several mattresses used to try to provide comfort. Observation with the social worker on 2/9/17 at 10:44 AM verified the mattress on the resident's bed was not an air mattress. Interview with the administrator on 2/9/17 at 11:40 AM verified the resident started out with an air mattress and several other mattresses had been tried. He further stated a new air mattresses had been received and was	F 282	**II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Other Residents residing in community have the potential to be affected by this deficient practice. The community completed an audit of other specialty air mattresses to ensure the plan of care accurately reflects the use of the specialty air mattress. The community will review at least four (4) care plans weekly to ensure the care plan accurately reflects the residents current status and that the care plan is being followed. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The Consultants provided re education and training with the IDT team on 4/4/2017. The community will review at least (4) care plans weekly to ensure the care plan is being followed. Any changes of condition will be reviewed daily (Monday through Friday) during morning stand up meeting. The DON or designee will be responsible to review the plans of care to ensure any changes or revisions are completed and that staff are executing the plan of care. The DON or designee will be responsible to report findings of the care plan audits to the QAPI Committee.	

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F 282	Continued From page 25 planned to be installed that day. The administrator verified the care plan was not followed as written due to the changes in the mattress.	F 282	**IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The DON or Designee will be responsible to report Care Plan audits to the QAPI Committee monthly until a lesser frequency is determined appropriate. The DON or Designee will be responsible to follow up on any recommendations.	
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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: Based on medical record review, hospital medical record review, staff interview, and professional standard review, the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical,	F 309	**Poplar F309** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION**	4/20/17

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F 309	Continued From page 26 mental, and psychosocial well-being were provided for 1 of 4 sample residents (#110) whose change in condition required immediate medical care. This failure resulted in actual harm for the resident, who was not transported to the hospital until a minimum of 3 hours and 26 minutes after staff were aware of the resident's symptoms of a heart attack (MI). The findings were: Medical record review showed resident #110 was admitted to the facility on 8/17/16 with diagnoses which included hypertension and dysphagia. The review showed the resident was transferred to a local hospital emergency department on 1/21/17 with a significant change in condition. At the hospital emergency room (ER) the resident was found to have had an MI (heart attack) and the hospital STEMI protocol (ST elevation MI, or heart attack) was initiated to address the resident's critical condition. Review of the resident's blood pressure (BP) readings prior to 1/21/17 included the following measurements: On 12/22/16 the reading was 127/80; on 12/23/16 the reading was 128/66; on 12/28/16 the reading was 147/67; on 1/4/17 the reading was 118/64; on 1/11/17 the reading was 115/63; on 1/16/17 the reading was 115/63, and on 1/18/17 the reading was 135/71. The following concerns were identified: 1. The facility failed to ensure a timely and ongoing comprehensive assessment concerning a significant change in condition for resident #110 as evidenced by the following: a. Review of a 1/21/17 note written at 6:45 AM by LPN #1 revealed the following: "CNA notified LPN that resident not acting like [himself/herself]. VS [vital signs] obtained, WNL	F 309	**OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Resident #110 no longer resides in the community; therefore, no individualized plan of correction is indicated. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** ~~Other Residents receiving dialysis~~ All residents have the potential to be affected by this deficient practice. The community has one (1) other resident who receives dialysis services. This resident has not had a change in condition or concerns related to pain management. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The community has implemented a morning QAPI stand up meeting and an afternoon follow up meeting. The facility has adopted a new 24 hour report which is reviewed every morning (Monday through Friday) by the	

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F 309	Continued From page 27 [within normal limits] with exception of BP of 64/48, rechecked several times. Resident able to respond verbally, denied any pain, NAD [no acute distress], lung sounds clear in upper fields, diminished in lower bilaterally, pedal pulses palpable, no edema noted, able to follow simple commands. Resident cooperative with AM cares, will pass information on to oncoming RN for further observation." No additional documentation was in the medical record until 1/21/17 at 10:11 AM (3 hours and 26 minutes later), written by RN #3 as follows: "Vital Signs: BP 78/48-1/21/17 10:17 (AM) Position: Sitting L/arm, P 78-1/21/17 10:19 (AM) Pulse Type: Regular, R 20-1/21/17 10:19 (AM) Route: W 159.6 lb-1/16/17 11:13 (AM) Scale: Chair Scale, O2 95.0%-1/18/2017 01:05 (AM) Method: Room air. RN Assesement/LPN Appearance of resident-What I think is going on with the resident is: concerns w/difficulty breathing and moist sounding R lobes. Additional Nursing Notes as applicable: Family/Health Care Agent Notified: Own responsible party, at 01/21/2017 10:00 AM: Primary Care Clinician Notified (via phone call): Dr. [physician's name] at 01/21/2017 10:00 AM." Review of the 1/21/17 SBAR Communication Form and Progress Note at 10:11 AM by RN #3 confirmed the nursing notes and had no additional information. b. Review of the 1/21/17, timed at 7:27 PM, note written by RN #3 showed the following interventions for resident #110 with no timeline documented (resident was at a local hospital when this note was written): "Resident sent to ER this a.m. for evaluation per Dr. [physician's name]. Received in report this a.m. that resident's BP was 62/48 in L [left] arm and 64/48 in R [right] arm. Unsure what time these BPs were obtained. Aides immediately began taking VS upon a.m. shift w/resulting BP of 78/48. Fluids were	F 309	Interdisciplinary team (IDT) and is reviewed by managers on the weekend. Additionally, the community has adopted a new morning briefing agenda which minimally covers the following survey related topics to include: potential discharges, grievances/compliments, safety concerns, care plans needing reviewed, housekeeping/laundry concerns, maintenance concerns, social service follow up issues, and medical record issues. The IDT team also receives a verbal nursing report from the nurses working the floor. The nurses report on any resident change of condition as well as any new physician orders. The IDT team also reviews any new incidents or occurrences (falls, smoking, elopements, injuries of unknown origin) that may have occurred in the past twenty four (24) hours. Lastly, the IDT team reviews any survey plan of correction follow up required. The facility reconvenes at 3:30 P.M. daily to ensure any follow up items identified during morning QAPI meeting have been corrected. Beginning on 4/4/17 the Consultants provided the Nursing department re education and training on change of condition, physician/resident representative notification, and the appropriate treatment of pain. Education was also provided to document on the 24 hour report and floor nurses report	

4/11/18

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F 309	Continued From page 28 immediately encouraged and provided w/no resistance from resident. O2 sat [saturation] was 95% at this time but when rechecked by this nurse, O2 sat was 82%. Provided breathing tx [treatment] per order w/resulting in O2 sat 84%. Began supplemental O2 at 2 lpm [liters per minute] via NC [nasal cannula] which increased O2 sat to 95%. Then lowered O2 to 1.5% w/resulting O2 of 91%. Resident appeared to be doing better, however, shortly thereafter, [s/he] became pale and lung sounds became moist. Called Dr. [physician's name] and received order to send to ER. This nurse checked BP prior to transport which resulted in 88/54 and pulse was 78. Resident was sent to ER via facility van w/facility transport staff." c. Interview with RN #3 on 2/9/17 at 10:26 AM confirmed the documentation for the significant change regarding resident #110 on 1/21/17 was not consistent because she felt the resident was improving. d. Interview with the DON on 2/9/17 at 1:10 PM confirmed his expectation for the change in condition for resident #110 on 1/21/17 would have been for nursing staff to have notified the physician when the resident became hypotensive, hypoxic, and was not acting like himself/herself, for staff to have followed physician orders, and for staff to have continued a timely and comprehensive assessment. 2. The facility failed to ensure an appropriate and timely transfer for resident #110 concerning a significant change in condition as evidenced by the following: a. Review of the nursing documentation on 1/21/17 at 6:45 AM showed the resident had a change in condition related to hypotension, hypoxia, and not acting like himself/herself. The	F 309	directly to IDT in morning stand-up (Monday - Friday) for follow-up. The DON or designee will audit for hospice notification, pain medication administration, and shower compliance weekly. Any identified concerns will be addressed immediately. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The DON or Designee will be responsible to report any concerns related to change of condition audits to the QAPI Committee monthly until a lesser frequency is determined appropriate. The DON or Designee will be responsible to follow up on any recommendations.	

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F 309	Continued From page 29 notes showed these issues continued; however, the facility failed to notify the physician until 1/21/17 at 10:00 AM (3 hours and 15 minutes later), when a physician order was obtained to transfer the resident to the local emergency department. At that time the facility failed to ensure an appropriate transfer via emergency medical services, and instead transported the resident to the local emergency room via facility van with one staff member, a CNA, who was the driver. b. Review of the local emergency department documentation showed resident #110 arrived at the ER on 1/21/17 at 11:41 AM via facility van with the van driver stating, "I think [s/he] has pneumonia or something, [s/he] isn't acting right and [s/he's] wheezing." The documentation showed the resident was usually on RA [room air], and ER staff placed [him/her] on 0.25 l NC [0.25 liters per minute via nasal cannula], BP noted to be 71/53 in triage, pt. [patient] unable to answer most questions. Review of an ER "Admission Report" from ER physician #1 written on 1/21/17 at 5:17 PM showed resident #110's chief complaint upon admission to the ER was being confused and having trouble breathing. The documentation showed the resident was confused and was poorly responsive. The documentation noted a 78 systolic BP and indicated the resident was markedly hypotensive in triage. The "Assessment" area of the ER documentation completed by ER physician #1 showed, "Acute ST elevation myocardial infarction [MI], possibly subacute as the patient does have Q-waves in V2 and V3 and his troponin is markedly elevated. This process has been going on for some time. Hypotension and tachycardia consistent with cardiogenic shock and poor perfusion. Marked lactic acidosis due to	F 309		

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F 309	Continued From page 30	F 309		

hypoperfusion and end-organ dysfunction. Marked lactic acidosis due to hypoperfusion and end-organ dysfunction. Acute kidney injury, likely associated with cardiogenic shock and poor kidney perfusion. Markedly elevated BNP [brain natriuretic peptide] and findings consistent with pulmonary edema, volume overload, and acute hypoxemic respiratory failure associated with cardiogenic shock." Review of discharge documentation on 1/21/17 signed by physician #2 at 10:05 PM and physician #3 at 10:32 PM confirmed the following: "Called by Dr. [physician's name] after nursing notified him of need to see patient regarding unresponsiveness for likely death. The patient was found to be breathless, pulseless, and without heart sounds, blood pressure, and corneal reflexes. The patient was pronounced dead at 1941 [7:41 PM] on January 21, 2017..."

c. Interview with RN #3 on 2/9/17 at 10:25 AM confirmed that in hindsight she should have sent resident #110 to the local emergency department by utilizing emergency medical services (911) instead of the facility van with one staff member, a CNA, who was the driver.

d. Interview with the DON on 2/9/17 at 1:10 PM confirmed his expectation for the change in condition for resident #110 on 1/21/17 would have been for staff to have notified the physician and contacted emergency medical services, not the facility van, for transport.

e. According to the americanheartassociation.org website, accessed 2/14/17, Under "Catch the signs early", the instructions include, "Don't wait to get help if you experience any of these heart attack warning signs. Although some heart attacks are sudden and intense, most start slowly, with mild pain or discomfort. Pay attention to your body and call

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F 309	Continued From page 31 911 if you feel...shortness of breath with or without chest pain." "According to the website http://www.heart.org/HEARTORG/Professional/Mission-Lifeline/Mission_Lifeline-Heart_Attack-101_UCM_314000_Article.jsp#.WLCy1zhRpEa, accessed on 2/14/17, at Mission: Lifeline Heart Attack 101, ..."In instances where a patient cannot access a PCI hospital within the golden 90-minute window, the best avenue of treatment might then be for the local hospital to administer clot-busting medicine."	F 309		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 334	**Poplar F334** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF**	4/11/17

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F 334	Continued From page 32 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that: (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 334	**CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Residents # 1, #3, #32, #42, #72, #73, #74,#79, #89, #100 were assessed for contraindications for pneumococcal immunizations and those who had no contraindications were offered the vaccine. Administration was given to those who accepted and documentation in the MDS assessments were updated to show accurate status of the pneumococcal immunization and the MR updated to include administration and site. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** The community completed an audit of other residents medical record to ensure regulatory compliance was achieved. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE**	

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F 334	Continued From page 33 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to implement a system for ensuring pneumococcal immunizations were offered and provided for 10 of 21 sample residents (#1, #3, #32, #42, #72, #73, #74, #79, #89, #100). The findings were: 1. Review of the medical records for residents #1, #3, #32, #42, #72, #73, #74, #79, #89, and #100 showed staff did not offer the pneumococcal immunization; nor did they assess the residents for medical contraindications. Further review showed no evidence the residents or resident's legal representatives were provided education regarding the benefits and potential side effects of pneumococcal immunization. Additional information regarding this concern was identified during review of the following MDS assessments: a. Review of the 1/9/17 quarterly MDS assessment for resident #1 showed the pneumococcal vaccine was not up to date and was "not offered." b. Review of the 12/1/16 quarterly MDS assessment for resident #3 showed the pneumococcal vaccine was not up to date and was "not offered." c. Review of the 12/13/16 quarterly MDS assessment for resident #32 showed the pneumococcal vaccine was not up to date and was "not offered." d. Review of the 12/5/16 quarterly MDS assessment for resident #42 showed the pneumococcal vaccine was not up to date and was "not offered." e. Review of the 9/19/16 quarterly MDS	F 334	**WILL NOT OCCUR AGAIN:** The SDC has been educated on the policy on screening, documenting, administration of vaccine (including site) in the medical record and providing the resident with the most current federal Vaccine Information Statement by the DON or designee. The Consultant also provided verbal expectations to the IDT team during morning QAPI on 4/4/2017. Newly admitted residents and /or Medical POA will be asked if the resident has had the pneumococcal immunization in the past. An assessment of potential medical contraindications will be conducted. Staff will offer the pneumococcal immunizations per policy to those who have no contraindications and the MDS assessment will be updated to accurately reflect the resident's pneumococcal immunization status. The LN staff were educated on the policy for immunizations by the DON or designee. The IDT will review newly admitted residents to ensure the for the pneumococcal immunization is offered as applicable. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The DON or Designee will be responsible to report any concerns related to pneumococcal immunizations	

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F 334	Continued From page 34 assessment for resident #72 showed the pneumococcal vaccine was not up to date and was "not offered." f. Review of the 1/17/17 quarterly MDS assessment for resident #73 showed the pneumococcal vaccine was not up to date and was "not offered." g. Review of the 2/15/17 significant change MDS assessment for resident #74 showed the pneumococcal vaccine was not up to date and was "not offered." h. Medical record review for resident #79, which included an 8/9/16 annual MDS assessment, a 9/30/16 annual MDS assessment, and a 1/3/17 quarterly MDS assessment showed the resident's Pneumovax status was undocumented and the Pneumovax vaccine was not offered. I. Review of the 12/29/16 quarterly MDS assessment for resident #89 showed the pneumococcal vaccine was not up to date and was "not offered." j. Review of the 11/28/16 quarterly MDS assessment for resident #100 showed the pneumococcal vaccine was not up to date and was "not offered." 3. Interview with the MDS coordinator on 2/9/17 at 2 PM confirmed there was no documentation regarding the residents' Pneumovax status. 4. Interview with the administrator on 2/7/17 at 4 PM confirmed the facility failed to ensure a tracking system for residents concerning their Pneumovax status. Interview with the ICP on 2/9/17 at 1:34 PM confirmed the facility had not completed tracking of the Pneumovax status for residents to ensure the Pneumovax vaccine was offered as appropriate. She stated the facility had	F 334	to the QAPI Committee monthly until a lesser frequency is determined appropriate. The DON or Designee will be responsible to follow up on any recommendations.	

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F 334	Continued From page 35 started the process, and had approximately 50% compliance at that time. 5. According to the policy and procedures for Resident Care Polices, revised 9/2016, staff were directed to vaccinate all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, screen all residents for contraindications and precautions; document the administration of the vaccine, including injection site, in the medical record or staff/volunteer immunization record; and provide all residents with a copy of the most current federal Vaccine Information Statement (VIS).	F 334		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types	F 353	**Poplar F353** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF**	4/10/17

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F 353	Continued From page 36 of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (e)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and review of staffing forms, the facility failed to ensure adequate numbers of staff were on duty to meet the needs of the residents and provide care in a respectful manner. The facility census was 104. The findings were: 1. Interview with the administrator on 2/8/17 at 1:45 PM revealed some staff had recently terminated their employment without giving notice. He stated the abrupt terminations made staffing a challenge and all staff were working	F 353	**CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** The Community entered into an agreement on 04/04/2017 with Pinnacol Quality Insight to complete 100% staff and resident satisfaction surveys. The Community Policy was in place that addressed staff responsibility for attendance however, this plan was not being enforced. Notification of policy enforcement has been posted at the time clock. An initial meeting was held with staff on 03/09/2017 to identify and address concerns. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Other residents residing in the community have the potential to be affected by this deficient practice.	

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F 353	Continued From page 37 together to fill those areas until new staff could be trained and hired. Interview with LPN #1 on 2/9/17 at 5:40 AM revealed he was working 12 hour shifts for 6 consecutive days that week. He stated staffing shortages were due to staff "call ins" and termination without notice. He further stated adequate numbers of staff on the day shift should be two CNAs for each hall and 4 nurses for the facility. 2. Review of the 1/25/17 to 2/8/17 Daily Nurse Staffing Form showed 3 nurses were on duty on the day shift on 1/27/17, 1/28/17, 1/29/17, 1/31/17, 2/2/17, 2/3/17, 2/4/17, 2/5/17 and 2/6/17. This review also showed there were fewer than 2 CNAs for each hall on 1/25/16, 1/26/17, 2/1/17, 2/3/17, and 2/5/17. Further review showed 4 CNAs with one nurse aide were on duty on the night shift on 2/3/17 and 2/4/17; and 4 CNAs without a nurse aide were on duty on 1/25/16 and 2/5/17. 3. Review of the 9/19/16 quarterly MDS assessment showed resident #72 was cognitively intact with a BIMS score of 15; and s/he needed assistance with ADLs. Review of the corresponding care plan showed staff were directed to assist the resident with repositioning. Interview with the resident on 2/7/17 at 8:45 AM revealed the facility was short-staffed because the wait for a response to call lights was as long as 30 minutes. S/he stated s/he periodically needed assistance to move from lying in bed to sitting on the bedside; and the discomfort increased during the prolonged time waiting for staff to respond to his/her request for assistance with repositioning. 4. Interview with resident # 32 on 2/8/17 at 4:17	F 353	**III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The community devised a new electronic staffing plan that when populated with census and PPD will identify the staffing requirements. The community also hired a new scheduler to assist with appropriate staffing and has contracted with travel nurses to supply the community with agency coverage until adequate staffing numbers could be reached with hiring. The community will also factor in acuity as census changes. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The NHA will be responsible to report to the QAPI Committee on a monthly basis a review of any concerns with maintaining adequate staffing minimums. The NHA or designee will be responsible to follow up on any recommendations made by the QAPI committee.	

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	535024	A. BUILDING _____ B. WING _____	02/08/2017

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F 353	Continued From page 38 PM revealed s/he had reourrent nose bleeds. The resident stated it was upsetting when blood oozed from his/her nose and staff did not respond promptly. The resident further stated the lack of staff caused anxiety because, at times, the blood saturated his/her clothing while s/he waited for staff to respond to his/her call light. Review of the 12/13/16 quarterly MDS assessment showed the resident's BIMS score was 11 (moderately cognitively impaired). 5. Interview on 2/8/17 at 10:29 AM with resident #76 revealed the staff were slow to respond to his/her requests such as getting up into the chair. The resident stated "last night between 9 PM and 12 PM" s/he called to have assistance to reposition in bed; his/her feet were hanging over the end of the bed. The aide who answered the call told the resident she could not help him/her. The aide told the resident a second person would be needed and there was no one else available to help; the resident would have to "do it [himself/herself]." Review of the 11/30/16 quarterly MDS assessment showed the resident was cognitively intact with a BIMS score of 13. 6. On 2/8/17 from 5:06 PM to 6:35 PM interviews were conducted individually with 11 staff members. Seven of the 11 staff members stated there were shortages of nurses and CNAs. During the interviews staff members gave the following information regarding inadequate staffing: a. Staff member #1 stated they had to "rush" and couldn't "give residents the time they want" and the residents told her she "works too hard." b. Staff member #3 stated "we're doing the best we can" and the "residents are missing	F 353		

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F 353	Continued From page 39 extra conversation." Staff member #6 stated they had to rely on finding managers, nurses and others who could help if they needed 2 people to assist a resident, the managers were not available on the weekends. She stated "residents say it's hard to get their medications on time." c. Staff member #7 stated the nurses were "overwhelmed." d. Staff member #8 stated on the day shift they were down 1 nurse and 1 aide and it got "a little rough" They were trying hard and they were "often a little late on medications." e. Staff member #9 revealed the inadequate staffing situation was "frustrating" and it "upsets the residents because they don't get the time and attention they need." The staff member stated "care is lacking" and it was "more difficult to do the care that is needed." The staff member also stated, "It is difficult around here because a lot of people have left." f. Staff member #10 revealed the facility was "short-staffed most of the time and nights are the worst." In addition, she stated "it [care] takes longer than what [the residents] want" and "there is very little help from nurses or administration on this shift."	F 353		
F 371 SS=E	483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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	F 371	**Poplar F371** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF**	4/10/17

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F 371	Continued From page 40 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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(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: Based on observation, staff interview, and resident interview, the facility failed to ensure food service articles were clean when used to serve meals to residents. In addition, the facility failed to ensure 1 of 2 ice machines was equipped with an air gap/back flow prevention device and that the interior was sanitary. The resident census was 104. The findings were: 1. Observation on 2/8/17 at 12:02 PM showed the ice machine located in the secured unit nurses' station was not sanitary on the interior. The inside of the ice bin had 2 areas of rust contamination. One was on the side of the bin where a screw had come loose. The screw was rusted and there was a rust-colored line from this screw into the ice bin. The other rust area was located on the metal shield that served as a guide for the ice as it fell into the bin. Interview with the registered dietitian (RD) on 2/9/17 at 1:20 PM verified the rust areas in the ice bin were a contamination issue and needed to be corrected. The RD further	F 371	**DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** The rust contamination in the ice machine located in the secured unit nurses station has been repaired and the screw has been removed. The air back flow for the ice machine has been checked and put into compliance with the food code. The water softener, along with a new chemical dispensing device was restored in the facility dish room. Water glasses, pitchers and coffee cups that were unable to be cleaned were disposed of and replaced with new ones.	

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F 371	Continued From page 41 revealed he had spoken with the maintenance director and they were uncertain based on the set-up of the ice machine if there was an air gap/back flow prevention device. According to Food Code 2013, U.S. Public Health Service: 5-204.12 Backflow Prevention Device, Location. A backflow prevention device shall be located so that it may be serviced and maintained. According to Food Code 2013, U.S. Public Health Service: 4-602.11 "...(E) Except when dry cleaning methods are used as specified under § 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold." 2. Interview on 2/7/17 at 10 AM with a group of 10 residents revealed they were concerned with the cleanliness of the glassware in the dining room. Observation on 2/8/17 at 11:15 AM showed a rack of beverage pitchers and cups located on the clean side of the dish room. There were more than 10 plastic drinking glasses, more than 20 coffee mugs, and 6 beverage pitchers noted to have white-ish colored film/spots on the surfaces.	F 371	**II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** The Dietary Manager has reviewed the inventory of glassware and pitcher for sanitation concerns. Those that cannot be cleaned have been disposed of and replaced with new glassware, coffee mugs and pitcher. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The Consultants provided re-education and training with the Dietary Manager and staff regarding kitchen sanitation expectation as well as reporting concerns with utensils or equipment. The Dietary Manager or designee will complete an audit/inspection of the plastic glasses, pitchers, and coffee mugs for any whitish spots or discoloration daily during meal times. Any that items are identified as uncleanable will be disposed of and replaced. The ice machines will be inspected by the Dietary Manager or designee will inspect the ice machines for rust and that the air gap is in place weekly. Noncompliance will be corrected at the time of discovery. The water softener and and chemical dispenser will be checked.	

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F 371	Continued From page 42 Observation on 2/9/17 at 3:18 PM showed the storage area for these items was stocked with 12 trays of the drinking glasses and 7 trays of coffee cups. The residue and spots were visible on many of these items. Interview with the dietary manager on 2/8/17 at 12:30 PM revealed the residue on the dishes was thought to be from hard water. The water softener had been removed about six months prior. She was not sure how long facility staff and residents had been seeing the spots and residue. 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	**IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The Dietary Manager or Designee will be responsible to report any concerns related to the kitchen inspection audits to the QAPI Committee monthly until a lesser frequency is determined appropriate. The Dietary or Designee will be responsible to follow up on any recommendations.	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by:	F 425	**Poplar F425** **PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN 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. FOR THE PURPOSES OF ANY ALLEGATION**	4/6/17

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F 425	Continued From page 43 Based on observation, resident and staff interview and medical record review, the facility failed to provide pharmacy services that ensured accurate administration of medications to meet the needs of 2 of 21 sample residents (#72, #100) and 1 non-sample resident (#4). This failure was evidenced by 3 residents (#4, #72, #100) who did not receive medications within an appropriate timeframe. The findings were: 1. Review of the February 2017 medication administration details summary report for resident #4 showed the resident was scheduled to receive Lasix 80 mg at 6 AM and 12 noon every day. Further review showed the resident did not receive the 6 AM dose on 12/9/17, but received the first dose of the day at 1:34 PM (this exceeded the appropriate administration time for both scheduled doses). Review of the medical record and the February 2017 medication administration details summary report on 2/9/17 at 5:09 PM revealed the 6 AM dose was not available and there was no documentation regarding the rationale for the delayed dose at 1:34 PM. 2. Interview with resident #72 on 2/7/17 at 10:40 AM revealed his/her symptoms were worse when the medication for Parkinson's disease (Sinemet) was not administered at approximately the same time each day. Review of the February 2017 medication administration details summary report showed scheduled doses of Sinemet were to be administered 4 times daily. Further review revealed from 2/4/17 to 2/8/17, 6 doses were administered 1 hour and 30 minutes to 3 hours past the scheduled administration time. Review of the medical record showed no documentation regarding the rationale for the delayed doses.	F 425	**THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.** **I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Residents #4, #72, and #100 have been notified of late medication administration. The physician and resident representative have also been notified of late medication administration. **II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** Other residents who receive medication in the community have the potential to be affected by this deficient practice. The community nursing staff have been re educated by the Consultants and or designee on the communities Medication Administration Policy and Procedure as well as the importance of timely	

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F 425	Continued From page 44 3. Review of the 11/28/16 quarterly MDS assessment for resident #100 showed diagnoses that included Parkinson's disease and GERD (gastroesophageal reflex disease). The following concerns were identified: a. Observation on 2/8/17 at 11:35 AM showed the resident was in the dining room for the lunch meal. The resident stated "I don't feel good" and pushed away from the table. The resident was taken out of the dining room to RN #1. The resident told the RN s/he felt "nauseated". The RN stated she had not had a chance to administer the resident's morning medications. The medications, Sinemet and Nexium, were administered at 11:44 AM and the resident was taken to his/her room to lay down. Review of the February 2017 MAR showed these medications were scheduled to be given at 9 AM. b. Review of the February MAR showed Nexium (medication to treat GERD) 40 mg was to be administered daily at 9 AM. Review of the "Administration Details Summary" for dates between 1/26/17 and 2/8/17 (15 days) showed 8 of the 15 scheduled doses of the medication were administered outside of the acceptable variance of 1 hour before or after the scheduled administration time; the longest being approximately 5 hours and 20 minutes on 1/25/17. All of the entries were coded as "0" (administered) with no documentation in regard to what caused the delay. c. Review of the February MAR showed Sinemet (medication to treat Parkinson's disease) 25-100 mg (milligrams) was to be administered by mouth twice a day at 9 AM and 5 PM. Review of the "Administration Details Summary" for dates between 1/29/17 and 2/8/17 (11 days) showed 7 of the 22 scheduled doses of the medication were	F 425	medication administration in accordance with physician orders. In the event a medication cannot be administered, nursing staff must report to the DON for additional review and follow up. **III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** The DON or designee completed Medication Administration Record Audits (MAR) to ensure residents are receiving medications as prescribed by their primary care physician. The DON or designee will round daily with nursing staff to ensure timely medication pass is occurring and complete weekly med pass audits to ensure compliance is achieved. Additionally, the DON or designee will complete weekly audits of MAR to ensure medications are being administered as prescribed. If concerns are identified, the DON or designee will be in charge notifying appropriate parties. The DON or designee will be responsible to report findings of the audits to the QAPI Committee. **IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The DON or Designee will be responsible to report MAR audits to the	

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F 425	Continued From page 45 administered outside of the acceptable variance of 1 hour before or after the scheduled administration time; the longest being 2 hours and 45 minutes on 2/8/17. All of the entries were coded as "0" (administered) with no documentation in regard to what caused the delay. d. According to Villerand, A.H. (2015). Davis's Drug Guide for Nurses (14th ed.). Philadelphia, PA: F.A. Davis Company, Sinemet showed be administered on a regular schedule. 4. Interview with the DON on 2/9/17 at 9 AM revealed nurses were required to administer medications as prescribed and within an hour of the scheduled time; use the electronic chart codes; and document the reason medications were not given as ordered. At that time, the DON reviewed the medication administration detail summary forms with the surveyor, and stated some of the documented inaccuracies were due to staff failure to make additions and revisions after their initial database entry. He further stated the facility was in the process of developing staff education to address the concerns identified in the above examples.	F 425	QAPI Committee monthly until a lesser frequency is determined appropriate. The MDS DON or Designee will be responsible to follow up on any recommendations.	