STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	05/11/2017

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

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F 000	INITIAL COMMENTS A recertification and complaint survey was conducted by Healthcare Licensing and Surveys on 5/8/17 through 5/11/17. The complaint survey was generated by complaint intake WY00002383. The following common abbreviations are used throughout this document: ADON- Assistant Director of Nursing CNA- Certified Nurse Aide CPR- Cardiopulmonary Resuscitation LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	*Preparation and/or execution of this Plan of Correction do not constitute admission or agreement of the truth of the facts alleged or set forth on this Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by various provisions of the Code of Federal Regulations.*	
F 155 SS=G	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 155	CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: Resident #77 expired. Nursing in-service was conducted by ADON and Nurse Managers to identify residents who are Full Code status, process of 'blue dot' placement, and AED/CPR procedure was reviewed. Full Code status identification process was reviewed on applicable residents. 04/25/17/& 04/26/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents who have Full Code status have the potential to be adversely affected if Full Code status identification processes are not implemented correctly, and/or AED/CPR procedure is not initiated per procedure.	4/25/17 4/26/17

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

William Hanlon | Administrator/Fac Mgr | 6/26/17

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

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F 155	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview,	F 155	MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: AED Procedure (WRC-35 policy) has been revised and updated by Facility Administration and submitted to ad-hoc QAPI committee meeting. 06/21/17 Nursing staff has been re-educated by the DON Nurse Manager on Residents' Rights regarding Advanced Directives, the updated Full Code Status process to include monitoring of lists in the facilities' defibrillators, and at the Nurses' medication carts; status is on a physician order in the residents' charts; documentation is on the Medication Administration and Treatment Administration Records; blue dot application to Full Code Status residents' charts and on residents' picture outside of his/her room; upcoming Code Drills; and appropriate language to EMS when requesting an ambulance. 06/20/17 & 06/21/17 Code Drills will be conducted monthly x 3 months for Nursing Staff (on random days & shifts) by the Nurse Managers to facilitate training of emergent actions during 'Code Blue' events. Medical Records will audit residents' charts monthly using a resident roster to determine correct code status is in place, and that all identification/notification/dots are in place and/or updated. Medical Records will validate Full Code Status residents have chart and door blue-dot indicators placed upon admission or upon readmission if the code status has changed. 06/22/17	6/21/17 6/20/17 6/21/17 6/22/17

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F 155	Continued From page 2 facility incident report review and policies and procedure review, the facility failed to implement the advance directives for 1 of 2 sample residents (#77) who expired in the facility. Resident #77 was a Full Code (CPR should be initiated) and staff did not perform CPR when the resident was determined to be without a pulse; the resident expired. The findings were: Review of the "Do Not Resuscitate/Resuscitate Request" form dated 2/3/16 (and signed by the physician 2/24/16) revealed resident #77 requested to be resuscitated. Review of the 3/10/17 social services quarterly note showed the resident was a Full Code status on his/her advance directives. The following concerns were identified: a. Review of the medical record showed conflicting information regarding the resident's code status. The "Physician Order Flow Sheet" and the "Care Plan Flow Sheet" for bathing both showed the resident was a Full Code. However, the care plan (dated 1/4/17) and the care plan flow sheet showed "Do not resuscitate (Do not do CPR)." b. Review of a nurse's note dated 4/22/17 at 10:10 AM revealed the resident was found on the floor. The resident was assessed, with no apparent injuries, and requested to use the bathroom. The resident was taken to the bathroom by two CNAs. After a few minutes, the resident was asked if s/he was done, but the resident did not respond. The nurse checked for pulses and tried to stimulate a response. Another nurse was retrieved; they tried sternal rubs. The nurse called the ambulance service, who stated if the resident was already dead, they would send funeral services. Death was noted at 9:20 AM. There was no evidence staff initiated CPR.	F 155	Code Blue-specific education will be incorporated into the Licensed Nurse new-hire education during Nursing-specific orientation. Admissions Team will verify that appropriate documentation supports admitting resident's preference for Advanced Directive of choice. **MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED:** Code Drill results will be submitted by DON Nurse Manager to QAPI at the monthly meeting for three months. Audits are submitted by Medical Records to QAPI at the monthly meeting for review and compliance, and then quarterly as needed.	

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F 155	Continued From page 3 c. Review of incident report information, faxed to Healthcare Licensing and Surveys (HLS) on 4/27/17 showed the resident was a Full Code, and confirmed the facility staff failed to initiate CPR. The documentation further showed all nursing staff were re-trained about the No Code and Full Code procedure. According to the facility's incident report staff were present with the resident in the bathroom when the resident became unresponsive. Staff were unable to find a pulse. Review of signed statements by the CNAs involved (CNA #4 and CNA #5) showed the CNAs and the nurse (RN #1) were in the bathroom with the resident when s/he became unresponsive. The written statement from CNA #5 revealed the resident was on the toilet and had been talking with staff. The RN asked the resident if s/he was finished, and the resident did not respond. The CNA's written statement further showed the CNAs and nurse checked for pulses, but could not find one. The CNAs stayed with the resident and the nurse left to call 911 and to get another nurse. d. During an interview on 5/10/17 at 3:52 PM the ADON stated the resident was a Full Code, but staff did not initiate CPR. She stated the resident used to be a DNR (Do Not Resuscitate), and the nurse thought the resident was still a DNR (review of the record showed an old DNR dated 8/15/11). The ADON also stated it was a newer nurse and this was her first resident death. The ADON stated the resident's chart had a blue dot on it, indicating Full Code, and the resident's name was on the slip of paper in the automatic defibrillator, also indicating Full Code. In addition, the ADON stated an ambulance was not dispatched, and speculated perhaps this was because the nurse told dispatch the resident was dead, instead of requesting assistance.	F 155		

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F 155	Continued From page 4 e. On 5/10/17 at 3:52 PM the ADON stated since the incident, nursing staff had been educated, the charts were reviewed to make sure they had blue dots for Full Codes, the list in the defibrillator was updated, and blue dots were put on the resident's picture outside their door to indicate Full Code status. However, the ADON stated she had not gone through the resident charts to verify the code status of each resident, to ensure the code status was correct. She also stated the facility did not have a system in place to ensure the code status was changed in all places (medical record, defibrillator, pictures on doors) if a resident revised their advance directive. Review of the facility's policy "Emergency Procedure- Cardiopulmonary Resuscitation" (dated April 2016) revealed "...If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless: It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or There are obvious signs of irreversible death (e.g., rigor mortis). If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR."	F 155		
F 166 SS=B	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 166	F 166 RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED:	

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F 166	Continued From page 5 (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing	F 166	No resident was identified as being adversely affected. WRC Policy modification for WRC-39 Resident Grievance Policy and Procedure (05/11/17) was approved, signed, and distributed to department managers and policy books, as well as a copy given to OHLS surveyors before exit on 05/11/17. The new policy details who the Grievance Officer is in the facility, and all of the contact information required to fulfill CMS regulations. This information includes name, address, phone number, and e-mail contact for the Grievance Officer. In addition, the policy was updated to include that the resident may file a grievance anonymously. In addition to the policy being updated, informational signage was placed near all Residents' Rights posters, resident common areas, and next to the Wyoming State Ombudsman contact poster. This informational poster includes contact requirements for the Grievance Officer, and that residents could file grievances anonymously. Furthermore this information was conveyed to Resident Council members at the next meeting (06/05/17) for both North and South Resident Council meetings. The updated Grievance Policy and Grievance officer contact information was also added to new admission packets. 05/11/17	5/11/17 5/11/17 6/5/17 5/11/17

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F 166	Continued From page 6 written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the	F 166	RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents have the potential to be negatively affected if they are not informed that there is an updated Resident Grievance Policy and Procedure that details how to contact the Grievance Officer in the building, to advocate for the residents' rights. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: Facility Grievance Officer/designee and facility Administrator will communicate weekly to ensure that when new CMS regulations occur they are immediately implemented into the policy per the deadlines established by CMS. WRC Policy modification for WRC-39 Resident Grievance Policy was updated and submitted to QAPI. 05/11/17 Employees have been educated by Social Services/Administration/DON Nurse Manager/Activity Manager on the Residents' right regarding grievance resolution. 06/26/17 Nursing staff has been educated by the DON Nurse Manager utilizing the Grievance Resolution developed by Social Services Director, on Residents' Rights regarding Right to have a grievance heard submit a grievance anonymously, and have prompt efforts to	5/11/17 6/26/17

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F 166	Continued From page 7 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on review of policy and procedure and staff interview, the facility failed to ensure the grievance policy contained all required information. The census was 74. The findings were: Review of "Grievance Policy and Procedure," last revised November 2013, showed the policy failed to include required information including the name, address, and phone number of the grievance official, the expected time frame for completion of the grievance, the contact information of independent entities with whom a grievance could also be filed, and did not address the right to file a grievance anonymously. Interview on 5/10/17 at 4:20 PM with the social worker confirmed the policy and procedure did not contain all necessary information.	F 166	resolve Grievances. Nursing staff has been in-serviced on appropriate process of documenting a grievance and the time frame for resolution. 06/20/17 & 06/21/17 MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: Grievance Policy will be reviewed by QAPI annually; employees will be educated on updates, and updates will be incorporated into the policy as needed. The facility Grievance Officer/designee and Administrator will review the new deadlines for CMS regulations and report to the facility QAPI committee at the monthly meeting to ensure continued compliance.	6/20/17 6/21/17
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and	F 226	F 226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: Resident #5, #18, and #65 were assessed per policy and remained safe. These residents had reports submitted. Employees were educated by the Administrator on the updated and revised Abuse Reporting Procedure for the 2-hour reporting window for all allegations of abuse or neglect at the All-Staff meeting. 05/23/17	5/23/17

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F 226	Continued From page 8 (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility investigation documentation, staff interview, and policy review, the facility failed to develop and implement a written policy related to reporting for 3 of 3 allegations of abuse or neglect reviewed (involving residents #5, #18, and #65). In addition the facility failed to revise policies related to reporting to ensure compliance with federal regulations. The findings were: 1. Review of facility investigation documentation revealed the following concerns: a. An allegation of verbal abuse involving resident #65 occurred on 1/10/17, but was not reported to Healthcare Licensing and Surveys (HLS) until 1/13/17.	F 226	The Abuse Policy and Procedure related reported abuse or neglect was revised by Administration to reflect the 2-hour window for reporting to OHLS, and was submitted to ad-hoc QAPI committee meeting. 05/31/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents alleging to have experienced abuse or neglect have the potential to be adversely affected if reporting is not done within the 2-hour time frame. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: All Staff in-service was presented by the Administrator on the revised reporting process related to Abuse Binders at Nurses' Stations. Abuse Incident packets were put at each Nurses' Stations for ease of access during all shifts. 06/13/17 Nursing staff was in-serviced by Administrator and DON Nurse Manager on identifying the various categories of potential abuse, and reporting alleged violations of abuse or other allegations that result in serious bodily injury within the required two hour timeframe. Nursing staff received education on Dementia Management and Resident abuse Prevention. 06/20/17 & 06/21/17	5/31/17 6/13/17 6/20/17 6/21/17

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F 226	Continued From page 9 b. An allegation of verbal abuse involving resident #18 was reported to the facility at 5:19 PM on 3/17/17, but was not reported to HLS until 3/18/17. c. An allegation of physical abuse involving resident #5 was reported to the facility at 9:20 AM on 4/10/17, but was not reported to HLS until 4/11/17. 2. During an interview on 5/10/17 at 4:20 PM the social worker confirmed the facility's policy had not been updated to reflect the new federal regulations and the facility was not reporting alleged violations of abuse or other allegations that result in serious bodily injury within the required two hour timeframe. 3. Review of the facility's policy "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations," last revised June 2015, showed "Any case of alleged abuse/neglect or misappropriation of resident property must be reported...Reporting agencies and their contact information are listed below in this section." The policy did not include a time frame required by federal regulation for reporting. 4. During an interview on 5/11/17 at 9:30 AM the facility administrator confirmed the facility's policy had not been updated to reflect the new federal regulations.	F 226	MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: Social Services/designee will monitor and submit audits regarding Federal regulations of timely reporting to QAPI at the monthly meeting for three months and then quarterly as needed, to verify sustained compliance. Abuse Policy will be reviewed by QAPI quarterly, and updates will be incorporated into the policy as needed. F 253 HOUSEKEEPING & MAINTENANCE SERVICES CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: No specific resident was identified as having been adversely affected. Radiator endcap was replaced for resident room 223. Identified cove bases were cleaned of dirt and debris accumulation. Activity bins were cleaned. 05/15/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Any resident utilizing areas on North or South wing of facility has the potential to be affected.	5/15/17
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 253	MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR:	

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F 253	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of cleaning schedules, and staff interview, the facility failed to ensure 2 of 2 resident areas (South and North wings) were clean and in good repair. The findings were: 1. Concerns identified on North wing: a. Observation on 5/10/17 at 2:40 PM showed the floor radiator in resident room #223 was missing the end cap off of its left side which exposed sharp edges. The cove base to the right of the closet door showed a 1 by 1 inch broken section which exposed a buildup of dirt and debris. A section of wall 5 inches wide and 36 inches long behind the head of the bed showed 24 scrapes of various sizes which exposed the underlying wallboard. 2. Concerns identified on South wing: a. Observation on 5/11/17 at 9 AM of the hallway floor between resident rooms #306 and #313 showed linear cracks that spanned fourteen 12 by 12 inch tiles and created a surface which could not be cleaned effectively. b. Observation on 5/11/17 at 9:10 AM in resident room #323 showed the cove base to the left of the closet nearest the entryway was loose from the wall which exposed a buildup of dirt and debris. c. Observation on 5/11/17 at 9:15 AM in the secure unit showed a white rack with 7 colored bins which contained items used for activities. Three of the bins contained dirt and dead insects. d. Observation on 5/11/17 at 9:20 AM in the secure unit dining area showed wax and dirt buildup on the cove base around the perimeter of the room.	F 253	Maintenance Manager and Environmental Services Manager have each created an audit for needed repairs and/or cleaning. These audits have been submitted to the Administrator for review and resolution. 06/20/17 & 6/26/17 Areas identified in the POC have been repaired, requisitioned for repair/ replacement, and/or cleaned by the responsible departments. 06/26/17 Environmental Services Manager has in-serviced staff on standards of cleanliness, consistent documentation of Cleaning Schedules, and how to notify appropriate managers of identified issues. 06/26/17 Environmental Services Manager/designee will audit compliance with Cleaning Schedules throughout facility monthly for three months. 06/26/17 Maintenance Manager has educated staff on expectations of keeping facility in good repair and how to notify appropriate managers of identified issues. 06/26/17 Nursing staff has been educated by Maintenance Director and DON Nurse Manager regarding the residents' right to have a clean, well-functioning and repaired home, and that every employee is expected to help achieve this. Nursing staff has been in-serviced by the Maintenance Director on the proper use of how to submit a work order (from yellow form to computer program) and the importance in respecting and supporting other departments by utilizing	6/20/17 6/26/17 6/26/17 6/26/17 6/26/17 6/26/17

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F 253	Continued From page 11 3. Review of the 2017 monthly schedule for deep cleaning showed the North wing had been cleaned in April. The South wing documentation showed A-pod and B-pod had been cleaned in February. The "entrance/coffee shop" had been cleaned in March, and the "hosp" and under the sink in the common area and been cleaned in May. All other areas listed were blank. 4. Interview on 5/11/17 at 9:55 AM with the maintenance manager confirmed the identified areas were in need of repair. In addition, he stated there were not any work orders pending for the areas reviewed. 5. Interview on 5/11/17 at 10:12 AM with the environmental services manager confirmed the areas identified were in need of cleaning. In addition, she stated it was her expectation the cove base throughout the building was to be cleaned once a month.	F 253	appropriate notification system(s). 06/20/17 & 06/21/17 Environmental Services Manager/designee will audit Cleaning Schedules weekly for one month, then twice a week for one month, and one time a month, and audits will be submitted to QAPI for verification of sustained compliance. 06/26/17 Maintenance Manager/designee will submit an audit on reported repair issues to Administrator/designee monthly for three months. 06/26/17 Activities Manager/designee will audit Cleaning Schedule log monthly for three months. 05/15/17 MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: Activities Manager/designee will submit results of Cleaning log audits to QAPI at the monthly meeting. Environmental Services Manager/designee will submit audits on Cleaning Schedules to QAPI at the monthly meeting. Maintenance Manager/designee will submit repair reports to the Administrator and to QAPI monthly meeting for verification of sustained compliance.	6/20/17 6/21/17 6/26/17 6/26/17 5/15/17
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED 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 care was provided in accordance with	F 282	F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: Resident #4 has an accurate care plan, and has verified functioning safety measures. Resident #14 was bathed.	

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F 282	Continued From page 12 the written plan of care for 3 of 13 sample residents (#4, #14, #36). The findings were: 1. Review of the 4/7/17 care plan for resident #4 revealed "Tabs alarm on when in wheelchair. Keep out of reach of resident. Make sure it is turned on each time [resident] is in chair. During an interview on 5/9/17 at 11:28 AM with the resident revealed that the Tabs alarm was needed because of a previous fall. S/he stated, "I fell out of my chair when I was trying to pick up a cookie. There was a lot of blood on the floor from hitting my head." The following concerns were identified: a. Observation on 5/9/17 at 10:58 AM showed CNA #1 and CNA #2 assisted the resident out of bed and into the wheelchair. At 11:28 AM the CNAs left the resident in the wheelchair in his/her room with the Tabs alarm not activated (not connected to the resident). At 11:45 AM CNA #2 returned to the room to take the resident to the dining room. The Tabs alarm was not activated before the resident was taken from his/her room. b. Observation on 5/9/17 at 4:55 PM revealed the resident was in the wheelchair in the main dining room. The Tabs alarm was on the wheelchair, but was not connected to the resident. b. Interview with the ADON on 5/11/17 at 8:32 AM revealed the Tabs alarm was a current intervention for falls and should have been in use when the resident was in the wheelchair. 2. Review of the care plan dated 3/23/17 for resident #14 revealed "Bath 1-2 times per week and as needed." However, review of the bathing documentation (CNA flowsheet and the bath aide wound and skin changes sheet) showed the following concerns:	F 282	Resident #36 no longer resides in facility. The staff has been in-serviced by the ADON and Nurse Managers on Resident Rights for falls and alarms. 04/25/17 & 04/26/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents having a written Plan of Care have the potential to be negatively affected when the care plan is not followed and care is not provided as identified as needed. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: Nursing staff has received education from the DON Nurse Manager regarding residents' Plan of Care regarding safety devices. The in-service directed that these devices are monitored at the beginning of each shift by Nursing Staff to verify the device is in place and functioning, as well as throughout the shift when the device is put into use. Any discrepancy of function is brought to the Licensed Nurses' attention for resolution. Licensed Staff have been in-serviced on accountability and monitoring for compliance to help residents be free from accidents and/or injury. In-servicing also included education on the importance of following residents' Plan of Care for a safe environment and for cleanliness. 06/20/17 & 06/21/17	4/25/17 4/26/17 6/20/17 6/21/17

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F 282	Continued From page 13 a. In March 2017, the resident only had 2 recorded baths, on 3/1/17 and 3/24/17 (23 days between). b. In April, the resident had a bath on 4/1/17, and then on 4/10/17 (9 days later). The resident had a bath on 4/15/17, and then again on 4/24/17 (9 days later). c. In May, the resident had a bath on 5/6/17. The previous bath recorded was 4/24/17 (12 days earlier). d. Further review of the bathing documentation showed no evidence of refusals. During an interview on 5/11/17 at 8:32 AM, the ADON stated there was no additional documentation related to bathing. She stated if a resident refused bathing, it should be documented. 3. Review of the medical record revealed resident #36 was admitted to the facility on 4/4/17. Review of the care plan dated 4/11/17 showed the resident was to receive a shower once or twice a week and required "assistance." Further review showed the resident was to sign the "bath book" if the shower was refused or if signing was declined then both the charge nurse and CNA were to sign the form. Review of the bath record for April 2017 and May 2017 showed the resident had a bath on 4/10, 4/16, 4/22 and not again until 5/4 (12 days). Further review of the medical record showed no documentation of refusals. Interview with the ADON on 5/11/17 at 8:30 AM verified there was not any additional documentation available in the medical record to explain the 12 day gap between showers.	F 282	MDS has provided a list of current alarms and safety devices at each Nurses' Station. This list will be updated by MDS as orders are received or safety devices are applied and/or changed. 06/21/17 The Bathing Documentation procedure and resident-specific Bath Sheet has been revised to involve Licensed Nursing in the accountability and monitoring, and was submitted to QAPI. 06/21/17 DON Nurse Manager/designee will audit for compliance with bathing weekly for one month, every other week for one month, and once a month for one month. 06/26/17 DON Nurse Manager/designee will audit for compliance with safety devices weekly for one month, every other week for one month, and once a month for one month. 06/26/17 MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: DON Nurse Manager/designee will submit audits on bathing and safety devices to QAPI monthly meeting for three months and then quarterly as needed, for verification of sustained compliance.	6/21/17 6/21/17 6/26/17 6/26/17
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312	F 312 CARE PROVIDED FOR DEPENDENT RESIDENTS CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED:	

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F 312	Continued From page 14 (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to ensure assistance was provided for 2 of 13 sample residents (#14, #36) who required assistance with bathing. The findings were: 1. Review of the 3/17/17 quarterly MDS assessment revealed resident #14 required limited assistance with bathing. Review of the care plan dated 3/23/17 showed "Bath 1-2 times per week and as needed." However, review of the bathing documentation (CNA flowsheet and the bath aide wound and skin changes sheet) showed the following concerns: a. In March 2017, the resident only had 2 recorded baths, on 3/1/17 and 3/24/17 (23 days between). b. In April, the resident had a bath on 4/1/17, and then on 4/10/17 (9 days later). The resident had a bath on 4/15/17, and then again on 4/24/17 (9 days later). c. In May, the resident had a bath on 5/6/17. The previous bath recorded was 4/24/17 (12 days earlier). d. Further review of the bathing documentation showed no evidence of refusals. During an interview on 5/11/17 at 8:32 AM, the ADON stated there was no additional documentation related to bathing. She stated if a resident refused bathing, it should be documented.	F 312	Resident #14 was assessed for intact skin by Licensed Nursing, and was bathed. Resident #36 no longer resides in facility. RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents who require assistance with bathing have the potential to be negatively affected if staff does not provide needed assistance. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: Nursing staff has been educated by the DON Nurse Manager regarding the residents' right to be offered and receive routine bathing. Discussion included infection control and the impact on skin integrity, as well as dignity and quality of life. Licensed Staff have been in-serviced on accountability and monitoring for compliance of direct-care staff. 06/20/17 & 06/21/17 MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: The Bathing Documentation procedure and resident-specific Bath Sheet has been revised to involve Licensed Nursing in the accountability and monitoring, and was submitted to QAPI. 06/21/17	6/20/17 6/21/17 6/21/17

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F 312	Continued From page 15 Observation on 5/10/17 at 5:30 PM revealed the resident's hair looked greasy. Interview with the resident at that time revealed s/he felt his/her hair was greasy, and stated bathing did not occur as frequently as it should. On 5/11/17 at 8:32 AM the ADON stated the resident's hair did tend to get greasy. 2. Review of the 4/10/17 admission MDS assessment showed resident #36 did not receive a shower during the 7 day look-back period. Review of the care plan dated 4/11/17 showed the resident was to receive a shower once or twice a week and required "assistance." Further review showed the resident was to sign the "bath book" if the shower was refused or if signing was declined then both the charge nurse and CNA were to sign the form. Review of the bath record for April 2017 and May 2017 showed the resident had a bath on 4/10, 4/16, 4/22 and not again until 5/4 (12 days). Further review of the medical record showed no documentation of refusals. Interview on 5/11/17 at 8:30 AM with the ADON verified there was not any additional documentation available in the medical record to explain the 12 day gap between showers.	F 312	DON Nurse Manager/designee will submit audits on compliance with bathing to QAPI at the monthly meeting and quarterly as needed for verification of sustained compliance.	
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: Resident #4 has an accurate care plan, and has verified functioning safety measures in place. The staff has been in-serviced by the ADON on Resident Rights for falls. 04/25/17 and 04/26/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents utilizing Plan of Care safety devices which are not correctly applied, or implemented, have the potential to be adversely affected. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR:	4/25/17 4/26/17

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F 323	Continued From page 16 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to ensure interventions were consistently implemented for fall prevention for 1 of 7 sample residents (#4) with a history of falls. The findings were: Review of the 1/26/17 quarterly MDS assessment showed resident #4 had diagnoses which included cerebrovascular accident, non-Alzheimer's dementia, hemiplegia, and epilepsy. The resident had total dependence on staff for bed mobility, transfers, toilet use, and required extensive assistance with locomotion on and off unit. S/he had one fall with injury since the prior MDS assessment. Review of Fall Injury Reports dated 12/5/16 and 3/18/17 revealed the resident had falls. Further review of the 3/18/17 fall showed the resident was lying on the floor and stated s/he dropped a cookie on the floor, and fell	F 323	Nursing staff involved have been educated by the ADON on Residents' Rights regarding falls. 04/25/17 & 04/26/17 MDS provided a list of residents' safety devices currently in place, and the list is available for reference to all Nursing staff at each Nurses' Station. 06/21/17 DON Nurse Manager/designee will audit for compliance with safety devices in place and functioning weekly for one month, every two weeks for one month, and one time a month for one month. Nursing staff has been educated by the DON Nurse Manager regarding the residents' right to have safety measures in place, and be free of accident hazards. Discussion was given regarding prevention of accidents and injuries, and quality of life. Licensed Staff have been in-serviced on accountability and monitoring for compliance of direct care staff. 06/20/17 & 06/21/17 MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: DON Nurse Manager/designee will submit results of audit for compliance with safety devices in place to QAPI at the monthly meeting for three months and then quarterly as needed, for verification of sustained compliance.	4/25/17 4/26/17 6/21/17 6/20/17 6/21/17

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F 323	Continued From page 17 out of the wheelchair while picking it up. The 3/30/17 Safety Assessment showed the resident's last fall was 3/18/17 and a Tabs alarm was a safety device in use. Review of the 4/7/17 care plan for the resident revealed "Tabs alarm on when in wheelchair. Keep out of reach of resident. Make sure it is turned on each time [resident] is in chair." The following concerns were identified: a. Observation on 5/9/17 at 10:58 AM showed CNA #1 and CNA #2 assisted the resident out of bed and into the wheelchair. At 11:28 AM the CNAs left the resident in the wheelchair in his/her room with the Tabs alarm not activated (not connected to the resident). At 11:45 AM CNA #2 returned to the room to take the resident to the dining room. The Tabs alarm was not activated before the resident was taken from his/her room. b. Observation on 5/9/17 at 4:55 PM revealed the resident was in a wheelchair in the dining room. The Tabs alarm was on the wheelchair, but was not connected to the resident. b. Interview with the resident on 5/9/17 at 11:28 AM revealed that the Tabs alarm was needed because of a previous fall. S/he stated, "I fell out of my chair when I was trying to pick up a cookie. There was a lot of blood on the floor from hitting my head." c. Interview with the ADON on 5/11/17 at 8:32 AM revealed the Tabs alarm was a current intervention for falls and should have been in use when the resident was in the wheelchair.	F 323		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371	F371 FOOD PROCURE, STORE/PREPARE /SERVE - SANITARY CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: No specific resident was identified as being adversely affected. Expired Health Shakes were disposed of after observation was made (05/08/17). Employees involved were educated on appropriate wearing of hair restraints on 05/12/17. Microwaves were immediately inspected and cleaned on 05/12/17. Dietary fans were inspected and cleaned on 05/11/17. Dietary staff was in-serviced regarding cleanliness of kitchen equipment. 05/12/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED:	5/18/17 6/12/17 5/12/17 5/11/17 5/12/17

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F 371	Continued From page 18 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (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 and staff interview, the facility failed to ensure 2 of 5 (North unit, South unit) microwaves throughout the facility and 3 of 4 fans in the kitchen were maintained in a sanitary manner. In addition, the facility failed to ensure health shakes were not expired in 1 of 6 refrigerators and failed to ensure staff properly restrained their hair while performing food preparation and serving tasks. The findings were: 1. Observation during the initial tour of the main kitchen on 5/8/17 at 4:42 PM revealed a tray in the reach-in refrigerator which contained 3 rows of health shakes. Two of the rows were labeled "Pulled 5/8/17" and those health shakes were partially thawed. The third row contained 28	F 371	Residents who have staff utilize microwaves and kitchen equipment which are not clean, residents who received thawed Health Shakes which are past the expiration date, and residents who have food served by staff not correctly restraining his/her hair, have the potential to be negatively affected. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: Dietary Manager/designee will add weekly fan cleaning to the kitchen cleaning schedule. 05/15/17 Dietary Manager/designee will audit fans and other devices to be kept in a sanitary condition, and correct wearing of hair restraints, daily for one month, two times a week for one month, and every other week for a month. Dietary Manager/designee will audit correct thawing, and disposal of Health Shakes outside of the 'use by' recommended process, twice weekly for one month, weekly for one month, and every two weeks for a month. 06/20/2017 Environmental Services Manager/designee will audit cleaning of microwaves daily for 30 days, then three times a week for one month, and weekly for one month. 06/20/17	5/15/17 6/20/17 6/20/17

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F 371	Continued From page 19 cartons of thawed health shakes that was labeled "Pulled 4/23." Review of the product information on the cartons revealed the product was good for 14 days after thawing. During an interview at that time the certified dietary manager (CDM) confirmed the 14th day was 5/7/17, and the product should have been removed from the refrigerator. 2. Observation on 5/8/17 at 4:59 PM of the South unit steam table revealed CNA #3 was dishing food at the steam table for residents. The CNA wore a hairnet, but her bangs were loose and not restrained with the hairnet. Observation on 5/9/17 at 11:48 AM in the main dining room showed cook #1 was dishing food at the steam table. She was wearing a hairnet, but the hairnet did not cover her bangs, which were hanging loose. Observation in the kitchen on 5/10/17 at 9:50 AM revealed dietary aide #2 was performing food preparation tasks. The hairnet she was wearing did not restrain her bangs. According to Food Code, 2013, by U.S. Public Health Service, Food and Drug Administration, 2-402.11 "(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 3. Observations on 5/10/17 at 5:30 PM and again on 5/11/17 at 9:10 AM revealed the microwave in the small kitchen/pantry on the North unit had dried splatters on the inside. Observation on	F 371	Nursing staff has been educated by the DON Nurse Manager on infection control and the responsibility of every employee to contribute to the cleanliness of the facility. Education included the purpose of wearing hair nets correctly. 06/20/17 & 06/21/17 **MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED:** Dietary Manager/designee will submit audits for correct wearing of hair restraints, the kitchen sanitation, and Health Shakes disposition, to QAPI at the monthly meeting for three months and then quarterly as needed, to verify sustained compliance. Environmental Services Manager/designee will submit audit results on Microwave cleaning to QAPI at the monthly meeting for three months and then quarterly as needed, to verify sustained compliance.	6/20/17 6/21/17

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F 371	Continued From page 20 5/11/17 at 9:08 AM revealed the microwave in the small kitchen/pantry in the South unit had dried splatters on the inside. An interview with the CDM on 5/11/17 at 9:20 AM revealed the night CNAs were responsible for cleaning the microwaves on the units. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. Observation on 5/10/17 at 9:50 AM in the main kitchen revealed a wall-mounted fan above the three-compartment sink. The fan was visibly dusty and dirty. There was also a fan sitting on a table near the deep fat fryer and a fan in the dishroom, on the clean side, that were also visibly dusty. Observation on 5/11/17 at 9:11 AM revealed the fans remained in the same condition. During an interview on 5/11/17 at 9:20 AM the CDM stated the fans were usually cleaned monthly, but acknowledged they might need to be cleaned more frequently. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 425 SS=E	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	F 425	F425 PHARMACEUTICAL SVC – ACCURATE PROCEDURES, RPH CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: No specific resident was identified as having been adversely affected. The medication stored incorrectly was verified as being stored per pharmacy recommendation. Expired medications were removed from the medication cart immediately after observation. 05/10/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents who receive medications not stored as recommended, or receive expired medications, have the potential to be adversely affected.	5/10/17

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F 425	Continued From page 21 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: Based on observation and staff interview, the facility failed to ensure medications available for resident use were not expired in 2 of 3 (white cart, blue cart) medication carts. In addition, the facility failed to ensure medication was stored as recommended in 1 of 2 (north) medication rooms. The findings were: 1. Observation on 5/10/17 at 3:51 PM in the white medication cart showed two medications cards for Hydrocodone-APAP 5-325 milligrams (mg) had expired; one on 12/10/16, and the other on 5/3/17. 2. Observation on 5/10/17 at 4:18 PM in the blue medication cart showed one medication card for Lorazepam 0.5 mg had expired on 1/26/17. 3. Observation on 5/11/17 at 9:52 AM showed Miacalicin nasal solution was lying flat in the north medication refrigerator. Review of manufacturer's instructions on the box showed "must store bottle upright." 4. Interview on 5/10/17 at 3:51 PM with RN #1 confirmed that the medications were expired and were available for use.	F 425	MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: Nursing staff has been educated by the DON Nurse Manager on the Standard of Practice regarding process of timely disposition of expired medications or obtaining a current medication, and correct storage of medications. 06/20/17 & 06/21/17 DON Nurse Manager/designee will monitor medications on each cart for expired medication, and for correct storage per recommendations, once a week for one month, every other week for one month, and one time in a month. MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: DON Nurse Manager/designee will submit audit results on medications' storage and expiration compliance to QAPI at the monthly meeting monthly for three months and then quarterly as needed, for verification of sustained compliance.	6/20/17 6/21/17
F 431	483.45(b)(2)(3)(g)(h) DRUG RECORDS,	F 431		

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F 431 SS=E	Continued From page 22 LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws,	F 431	F431 DRUG RECORDS CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: No specific resident was identified as having been adversely affected. No medications were expired per the manufactures' printed expiration date on the physical container. RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents who receive medications which are not labeled in accordance with current professional standards have the potential to be affected. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR: Clarification polices were received from Pharmacy regarding the practice of using expiration dates on original packaging or repackaged medications. 06/21/17 Nursing staff has been educated by the DON Nurse Manager regarding following the Wyoming State Board of Pharmacy directives on expiration labels, as well as prohibiting obliteration or destruction of a pharmacy/medication label. Medication labels were replaced with correct labels or an order was obtained to discontinue the medication as appropriate. 06/20/17 & 06/21/17	6/21/17 6/20/17 6/21/17

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F 431	Continued From page 23 the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications were labeled in accordance with current professional standards in 2 of 2 (South, North) medication rooms. The findings were: 1. Observation of the south medication room showed the following: a. Lantus solution 100 unit/milliliter (100 unit/ml) injection pens with the label expiration date blacked out. b. Novolog 100 unit/ml flex pens with the label expiration date blacked out. c. Humalog 100 unit/ml flex pen with the label expiration date crossed out. d. Valproic acid 250 milligram/5 milliliter (250 mg/5 ml) with the label expiration date whited out. e. Phenytoin 125 mg/5 ml with the label expiration date crossed out. f. Lactulose 10 gram/15 ml (10 gm/15 ml) with the label expiration date blacked out. g. Nyamyc 100,000 units/gram with the label expiration dated blacked out.	F 431	The Pharmacy Consultant will include medication label compliance during the monthly consult. Pharmacy Director has scheduled a Licensed Nursing in-service focusing on expiration dates and repackaged medications versus originally packaged medications to be offered during the next scheduled visit. 07/05/17 DON Nurse Manager/designee will monitor medications for appropriate expiration labeling once a week for one month, every other week for one month, and one time a month. Concerns will be addressed to the Pharmacy Consultant. MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED: DON Nurse Manager/designee will audit for medications with appropriate expiration labeling and submit results to QAPI at the monthly meeting for three months and then quarterly as needed, for verification of sustained compliance.	7/5/17

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F 431	Continued From page 24 2. Observation of the north medication room showed the following: a. Miacalcin nasal spray with the label expiration date blacked out. b. Humalog 100 unit/ml injection pens with the label expiration date crossed out. c. Lorazepam 2 mg/ml vial with the labeled expiration date of 12/3/16 crossed out. d. Procit 10,000 unit/ml vial with the labeled expiration date of 3/25/17 crossed out. e. Procit 10,000 unit/ml vial with the labeled expiration date of 2/27/17 crossed out. f. Ceftriaxon 1 gram/lidocaine 1% with the labeled expiration date of 2/26/17 crossed out. g. 2 Potassium chloride extended release bottles with the labeled expiration dates of 2/20/18 crossed out and hand written expiration dates of 7/19 and 10/19. 3. During an interview on 5/10/17 at 2:30 PM RN #2 stated "We go with the bottle expiration date and mark out the label date. The bottle expiration date is longer, so we use it instead." She stated that insulin, once opened and dated, expired 28 days after opened. She did not talk, however, about how long they could use other medications. At that time the RN was observed crossing out a label date on a medication in the south medication room. 4. Interview on 5/10/17 at 3:32 PM with pharmacist #1 revealed "We black out the expiration date on the label. They are to go by the bottle expiration date. For example on insulin they can sit in the refrigerator for 3 months. Once it is taken out they need to date it. They know they have 28 days. The nurses know when the medications should be thrown out."	F 431		

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F 431	Continued From page 25 5. Interview on 5/10/17 at 3:25 PM with the ADON revealed she had no policy or procedure on changing of the expiration dates on medications. 6. Review of Centers for Medicare & Medicaid Services website (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/lewingroup.pdf) showed: "Labeling requirements are standard across states, but are typically reserved for other than unit dose packaging (e.g., vial), as unit dose packaged medications are rendered patient specific through the use of medication carts and specialized packaging. As a result, medications in unit dose packaging generally have less detailed labels that include the name and address of the facility, date dispensed, name of prescriber, name of patient, directions for use, name and strength of drug and expiration date." Further the document states the long term care pharmacy services should "Ensure proper labeling." 7. Review of Wyoming State Board of Pharmacy (http://pharmacyboard.state.wy.us/laws/), Chapter 2, section 11. Labeling Prescription Drug Containers. (iv) Manufacturer's expiration date. If prepackaged or repackaged by the pharmacy, the expiration date shall be the lesser of the manufacturer's expiration date or twelve (12) months from the date of prepackaging or repackaging. Chapter 15, Section 4. Pharmacy Responsibilities. A provider pharmacy shall be responsible for: (a) Dispensing drugs pursuant to a medication order for an individual resident, properly labeled for that resident, as addressed in chapter 2, including the manufacturer's expiration date. If prepackaged or repackaged by the	F 431		

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F 431	Continued From page 26 pharmacy, the expiration date shall be the lesser of the manufacturer's expiration date or twelve (12) months from the date of prepackaging or repackaging.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS CORRECTIVE ACTION FOR THOSE RESIDENTS AFFECTED: Resident # 75 had his catheter bag covered upon identification of the deficient practice. Resident #76 and Resident #57 had no adverse effect from the events identified. Resident #38 (No resident #38 is listed on the Resident/Patient /Client List.) Glucometers were sanitized after observation was identified as deficient. 05/11/17 RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED: Residents who are incorrectly assisted with meals, have exposed catheter bags or bags touching the floor, or have glucose monitoring done with an unsanitized glucometer, have the potential to be adversely affected. MEASURES PUT INTO PLACE TO ENSURE DEFICIENCY DOES NOT RECUR:	5/11/17

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F 441	Continued From page 27 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of policy and procedures, and review of the manufacturer's instructions, the facility failed to ensure infection prevention practices were followed by staff during 1 random observation of a resident with an indwelling catheter, 2 random	F 441	Nursing staff has been educated by the DON/Nurse Manager on the Right of the resident to have dignity and privacy of a catheter bag, as well as the heightened potential for infection from the bag having contact with the floor. Nursing staff have received additional glucometer testing units and have been in-serviced on the correct sanitization of the units, including the time frame of 'wet contact for two minutes'. Nursing staff have been educated on the correct process of hand washing between resident contact when assisting with meals. Personal Protective Equipment (PPE) was reviewed with staff, including the purpose of correct placement, and the enhanced risk of spread of infection when not properly utilized. 06/20/17 & 06/21/17 Dietary Manager had the Registered Dietitian educate staff on Personal Protective Equipment (PPE) including the purpose of correct placement. 06/07/17 Dietary Manager/designee will monitor correct use of PPE once a week for one month, every other week for one month, and once in a month. DON Nurse Manager/designee will monitor glucose sanitization process, and catheter bag privacy cover placement, once a week for one month, every other week for one month, and one time for one month. MEASURES TO ENSURE CORRECTIVE ACTION IS ACHIEVED AND SUSTAINED:	6/20/17 6/21/17 6/7/17

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F 441	Continued From page 28 oberservations of glucometer use and 2 of 2 meal observations. The findings were: Regarding catheter bags: 1. Observation on 5/8/17 at 4:34 PM showed resident #75 was in his/her bed and his/her uncovered Foley catheter collection bag was lying on the floor. Regarding hand hygiene: 1. Observation on 5/9/17 at 12:13 PM showed Nursing/Student Aide (N/SA) #1 sat down without washing her hands and started feeding resident #57. She got up and took a rag from a drawer and cleaned up a liquid spill, placed the rag in the dirty dish container and went back to feeding the resident. At 12:18 PM she got up and went around the table to resident #76, and picked up the utensils the resident had been using and cut up the resident's food. She then returned to the resident she was previously assisting and started feeding him/her again, without performing hand hygiene. 2. Interview on 5/11/17 at 10:16 AM with the infection control nurse confirmed that staff were trained upon hire. In addition, she stated it was her expectation that staff perform hand hygiene between assisting residents. Regarding glucometers: 1. Observation on 5/9/17 at 8:50 AM showed RN #3 was training LPN #1. A blood glucose level was obtained on resident #38 by LPN #1. After the procedure was completed the glucometer was placed into the medication cart without being	F 441	Dietary Manager/designee will submit audits correct use of PPE to QAPI at the monthly meeting for three months and then quarterly as needed, for verification of sustained compliance. DON Nurse Manager/designee will submit results of audits on glucose sanitization process, and catheter bag privacy cover placement, to QAPI at the monthly meeting for three months and then quarterly as needed, for verification of sustained compliance.	

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F 441	Continued From page 29 cleansed by the LPN. Interview on 5/9/17 at 9:20 AM with RN #3 revealed it was her expectation the glucometer be wiped down with an alcohol swab before being placed into the medication cart. Interview with the LPN at this time revealed "I did not know I was supposed to" clean the glucometer. 2. Observation on 5/9/17 at 4:30 PM showed RN #1 wiped a glucometer off with 1 germicidal wipe (McKesson) and left the glucometer sitting on the medication cart. a. Review of the Assure glucometer maintenance recommendations revealed it could be cleaned by wiping the meter down with soap and water or isopropyl alcohol, but that would not disinfect the meter. Disinfecting could be accomplished with an EPA-registered disinfectant detergent or germicide that was approved for healthcare settings or a solution of 1:10 concentration of sodium hydrochloride (bleach). b. Review of McKesson disinfectant showed the product "effectively kills microorganisms at room temperature with a 2 minute contact time when used as directed." c. Review of cleaning and disinfection of resident-care items and equipment policy and procedure, revised August 2009 states, "3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident." 3. During an interview on 5/11/17 at 10:16 AM the infection control nurse stated it was her expectation that staff clean glucometers after each use. Regarding face masks:	F 441		

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WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 441	Continued From page 30 1. Observation in the main dining room on 5/9/17 from 12:01 PM until 12:08 PM showed dietary aide #1 wore a face mask while serving trays to residents. Further observation showed the mask only covered the resident's mouth; the resident's nose was not covered. Interview with the dietary aide on 5/9/17 at 12:08 PM revealed s/he had "a cold" and therefore was wearing a mask. 2. Review of the facility's policy "Personal Protective Equipment- Using Face Masks" (dated August 2011) showed "...Place the mask over the nose and mouth." 3. Interview on 5/11/17 at 10:16 AM with the infection control nurse revealed staff should wear face masks in an effective manner	F 441		