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

PRINTED: 07/06/2017
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
	535027	A. BUILDING _____ B. WING _____	06/22/2017

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/19/17 through 6/22/17. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing Services MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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. (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	F 166	The facility will provide residents the right to prompt efforts to resolve grievances. 1. The facility grievance policy has been updated to reflect the updated language of the regulation 483.10(j)(2)-(4). 2. The posting is now updated to reflect the agencies to which a resident may file a grievance anonymously outside the facility. 3. Residents were notified at the 7-12-17 resident council meeting about this process. 4. At future resident council meetings, the Administrator or Social Worker will remind residents of the grievance process. 5. Resident Council notification dates will be reported to the PI/QI Committee on a quarterly basis.	7/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski | TITLE: Administrator | (X6) DATE: 7/19/17

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 166	Continued From page 1 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 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;	F 166		

7/20/17 - This POC accepted between Terese Luther, DON and Tony Madden, State Health Surveyor.

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F 166	Continued From page 2 (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 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 79. The findings were: Review of "Concerns/Complaints of residents or family," last revised October 2000, showed the policy failed to contain all required information including the name, address, and phone number of the grievance official, the expected timeframe for completion of the grievance, the contact information of independent entities with whom a	F 166		

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F 166	Continued From page 3 grievance could also be filed, and did not address the right to file a grievance anonymously. Interview with the administrator on 6/22/17 at 12:50 PM confirmed the policy did not contain the required information.	F 166		
F 225 SS=E	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(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 (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:	F 225	The facility will ensure that pre-employment screening of the nurse aide abuse registry is completed before hiring CNA's. 1. Employee files for CNA's 1, 2, 3 and 4 have been updated with the documentation showing evidence that the CNA abuse registry was checked. None of these CNA's had any prior substantiated abuse findings on their records. The HR department will review past CNA new hire documentation and run abuse registry checks on those files for the past year. 2. The HR department has now included this check as part of the new hire orientation process checklist for CNA's. 3. Verification that the CNA Abuse Registry has been checked will be monitored by the HR department by monthly chart reviews and reported to the PI/QA committee on a quarterly basis to ensure compliance.	8/4/17

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F 225	Continued From page 4 (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 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 employee record review and staff interview, the facility failed to ensure pre-employment screening of the nurse aide abuse registry was completed for 4 of 4 CNAs reviewed (CNA #1, CNA #2, CNA #3, CNA #4). The findings were:	F 225		

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F 225	Continued From page 5 1. Review of the employee file for CNA #1 showed a date of hire of 6/19/17. Further review showed no evidence the nurse aide abuse registry was checked to ensure the CNA had no findings of abuse prior to resident contact. 2. Review of the employee file for CNA #2 showed a date of hire of 6/19/17. Further review showed no evidence the nurse aide abuse registry was checked to ensure the CNA had no findings of abuse prior to resident contact. 3. Review of the employee file for CNA #3 showed a date of hire of 5/1/17. Further review showed no evidence the nurse aide abuse registry was checked to ensure the CNA had no findings of abuse prior to resident contact. 4. Review of the employee file for CNA #4 showed a date of hire of 5/15/17. Further review showed no evidence the nurse aide abuse registry was checked to ensure the CNA had no findings of abuse prior to resident contact. 5. Interview with the human resources coordinator on 6/22/17 at 9 AM revealed she was unaware of the CNA abuse registry or the requirement that it be checked.	F 225		
F 244 SS=D	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 244	The facility will listen and act on group grievances and recommendations in accordance to 483.10(F)(5)(iv)(A)(B).	8/1/17

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F 244	Continued From page 6 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes, and resident and staff interview, the facility failed to ensure grievances from the resident council were acted upon and followed through to resolution for 3 of 3 months (November 2016, March 2017, May 2017) reviewed. The findings were: 1. Review of the resident council meeting minutes for November 2016, March 2017, and May 2017 showed concerns were discussed related to resident's clothes not being returned from the laundry. The following concerns were noted: a. Interview with 13 residents on 6/20/17 at 1:30 PM revealed there was no improvement with regard to issues brought up in previous resident council meetings, and the staff did not seem to try and fix the issues. Resident #53 stated, "they say they are working on it but it still continues." In addition, s/he stated, "they say you didn't mark it [the clothes] good enough." b. Interview with resident #67 on 6/20/17 at 3:30 PM revealed s/he reported missing laundry to the "higher ups" and they had him/her document the items that were missing including 4 pairs of jeans and 4 undergarments. S/he said one of the undergarments had been found but the other items were still missing. Further, s/he stated	F 244	1. The issue of missing laundry was discussed at the 7-12-17 resident council meeting of which resident #'s 66 and 67 attended. It was stated by the Administrator that we will be purchasing a new clothing labeling ID system to be utilized by nursing staff which should eliminate the clothing not being able to be identified by laundry so that it can be returned to residents. 1a. Resident #66 was interviewed by the Social Worker on 7-14-17 to investigate her comments on lost clothing. She said that she has always done her own laundry and had not further complaints. 1b. Resident #67 was interviewed by the Social Worker regarding her comments on lost laundry. She felt that she should be paid for the loss of clothing items. The facility will agree to pay that amount. 1c. Resident #78 was interviewed by the Social Worker regarding her comments on lost clothing. She replied that that several LL Bean clothing items were missing from a couple of years ago and provided the approximate cost of the clothing. The facility will agree to pay that amount.	

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F 244	Continued From page 7 "I'm doing my own laundry now." c. Interview with resident #66 on 6/20/17 at 3:30 PM revealed s/he was told by another resident to not send clothes to the laundry because they never come back. In addition, s/he stated "no one has marked or told me to mark my own clothes since I've been here. I'm going to be doing my own laundry." d. Interview with resident #78 on 6/20/17 at 3:51 PM revealed s/he did his/her own laundry now as s/he had several clothing items that were never returned from the laundry. In addition, s/he stated the staff says "they're sorry, they will look, I don't think anyone even looks for the missing items anymore." 2. Interview with the laundry supervisor on 6/22/17 at 8:40 AM confirmed she was aware there were issues with residents and POAs (Power of Attorney) marking resident clothing for identification, and the resident council had brought the issue of missing clothing to her attention. The laundry supervisor stated she had ordered labels for resident clothing and planned to start utilizing the labels for the darker clothing initially. She further stated the facility failed to inform the residents of the purchase of labels, and the facility did not have a plan with a timeframe to discontinue the practice of having residents and POAs label clothing.	F 244	2. The Unit Clerks will be trained in how to use the clothing identification labeler. 3. Lost clothing items from the laundry department will be tracked monthly after the clothing labeling ID system is in place to determine how effectively the process is working. 4. At care plan meetings, discussion will include the residents' satisfaction with laundry service. 5. The results of these audits will be presented at the quarterly PI/QI meeting.	
F 248 SS=E	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 248	The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident.	8/4/17

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F 248	Continued From page 8 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, review of the activity calendar, and activity attendance records, the facility failed to offer adequate activities during weekends. The facility census was 79. In addition, the facility failed to provide a meaningful and ongoing program of activities designed to meet individual interests and improve or maintain the physical, mental, and psychosocial well-being of 5 of 13 (#49, #53, #69, #75, #77) sample residents that participated in activities. The findings were: 1. Interview on 6/20/17 at 1:30 PM with a group of residents revealed they were concerned about the lack of activities offered on the weekends. Of the 13 residents present, 8 had concerns because the only activities offered included a movie or church services. The residents' statements included, "we don't feel like we are getting enough activities," "we want to be able to use our brains and have something to show for it," and "it is pretty quiet from Friday night to Monday morning, it's boring and long." 2. Review of the June 2017 activity calendar showed the activities offered on Saturdays included a movie and on 6/17 and 6/24 a "weekend fun activity." Further review showed activities offered on Sunday included church services and on 6/4 and 6/11, "music therapy."	F 248	1. Activities staff addressed residents regarding the survey results at the resident council meeting on 7/12/17. They will be adding more weekend hours to their schedules, and activities to the weekend calendar starting on 7-15-17 to include outings and activities that have an outcome or finished project (i.e., crafts). They are also providing a bulletin board for 2nd floor residents to express their input on different types of activities and engagement preferences. 2. For resident #'s 49, 53, 69, 75 and 77 new activity assessments will be conducted by the Activities Assistant. From these assessments an individualized activities plan will be developed and provided to the residents, and this activity plan will be reflected on the residents' comprehensive plan of care. The remaining resident care plans and assessments will be reviewed and updated as needed. Upon admission, new residents will be assessed for their preferences for individual and group activities.	

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F 248	Continued From page 9 3. Review of the activity attendance documentation for the East wing and 2nd floor for May 2017 showed attendance records for residents in both living areas were documented on 4 days out of the month and June 2017 attendance was documented on 6/5, 6/12, 6/13, 6/14, 6/15, and 6/16. 4. Review of the medical record for resident #77 showed the resident had an activity assessment dated 2/13/17 with corresponding MDS update at section F on 2/13/17. The documentation showed the following was very important to the resident: having books, newspapers, and magazines to read, keeping up with the news, and participating in his/her favorite activities. However, review of activity attendance records showed the facility failed to consistently document whether the activities met the resident's needs. Interview with resident #77 on 6/21/17 at 5:30 PM revealed s/he was not always notified of the activities that were happening in the facility, "they [staff members] don't come in and notify me." In addition, s/he stated, "I don't get asked if there are any activities that I would like to see added to the calendar; I feel like I'm a non-person." 5. Review of the medical record for resident #69 showed the resident had an activity assessment dated 10/22/13 with MDS update at section F on 4/10/17. The 4/10/17 documentation showed the following was very important to the resident: having books, newspapers and magazines to read, keeping up with the news, doing things with groups of people, doing favorite activities, going outside when the weather was good, and participating in religious activities. However, review of activity attendance record showed the	F 248	3. Activity participation will be documented daily and summarized in the residents' medical record at least quarterly. 4. The results of activity participation documentation will be reviewed monthly by the Administrator or Nurse Manager, and the results reported at the quarterly PI/QI meeting.	

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F 248	Continued From page 10 facility failed to consistently document the activities the resident participated in or refused to participate in, or whether the activities met the resident's needs. Interview with the resident on 6/20/17 at 8:30 AM revealed s/he was not always aware of activities that were going on in the facility in a timely manner. In addition, s/he stated the weekend activities consisted of church services and music, and s/he wanted more activity opportunities. The resident stated the facility was aware of this and nothing changed. 6. Review of the medical record for resident #53 showed the resident had a spiritual assessment completed by the activity assistant on 1/31/12 with MDS update at section F on 12/6/16. The 12/6/16 documentation showed the following was very important to the resident: listening to music, being around pets, doing things with groups of people, and doing his/her favorite activities. However, review of activity attendance records showed the facility failed to consistently document the activities the resident participated in or refused to participate in, or whether the activities met the resident's needs. Interview with resident #53 on 6/20/17 at 8:55 AM revealed the facility failed to provide meaningful activities on the weekends. S/he stated the resident council had made the facility aware that residents wanted more activities on the weekend, and would like more interactive activities and more outings. S/he also stated the facility did not always make all residents aware when an activity took place, so sometimes residents did not have the opportunity to attend the activities in a timely manner. 7. Review of the medical record for resident #49 showed s/he had an activity assessment dated 11/1/16 with corresponding 11/1/16 MDS update	F 248		

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	535027	A. BUILDING _____ B. WING _____	06/22/2017

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F 248	Continued From page 11 at section F. The documentation showed the following was very important to the resident: music, being around animals, keeping up with the news, doing favorite activities, and going outside when the weather was good. However, review of activity attendance records showed the facility failed to consistently document the activities the resident participated in or refused to participate in, or whether the activities met the resident's needs. In addition, the facility failed to address consideration for 1 on 1 activities due to the resident's aphasia and subsequent challenges for the resident when interacting with other residents. 8. Review of the medical record for resident #75 showed the resident had an activity assessment dated 11/4/11 with MDS updated at section F on 9/23/16. The documentation showed the following was very important to the resident: books, newspapers, and magazines to read, keeping up with the news, doing things with groups of people, and doing favorite activities. However, review of activity attendance records showed the facility failed to consistently document the activities the resident participated in or refused to participate in, or whether the activities met the resident's needs. 9. Interview on 6/22/17 at 12:45 PM with the activities director and activities assistant revealed residents were given a monthly calendar of events and staff went room to room to notify residents of the activities. They also stated the activities assistant only worked one weekend a month and they were working on getting more outdoor activities. Further, Saturdays were family days, and movies and 3 different church services were offered on the weekend. In addition, they stated music therapy was new and was offered	F 248		

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F 248	Continued From page 12 twice per month.	F 248		
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 3 resident areas (East wing, Second floor, Secure unit) were clean and in good repair. The findings were: 1. Observations of the second floor resident areas on 6/22/17 at 8:30 AM revealed the following issues with building repairs: a. In room #207 on the left side of the bathroom floor a 2 inch by 2 inch hole was observed just above the baseboard. b. In room #208 a corner on the right side of the bedroom showed an area of wall just above the baseboard to 30 inches high that had damage which exposed the metal underneath the wall and created a surface which could not be effectively cleaned. c. In room #214 the floor surface by the first bed was observed to have 8 chips in the linoleum which were darkened with dirt and debris, the longest chip measured 1 inch. d. In room #215 by the first bed the linoleum floor was observed to have multiple cracks in a 14 inch by 12 inch area that was darkened with dirt and debris. e. In room #217 the left side of the bathroom floor was observed to have a crack that extended the entire length of the floor, and was darkened with dirt and debris.	F 253	The Director of Plant Operations will ensure that the housekeeping and maintenance services are provided to maintain a sanitary, orderly and comfortable interior. 1. West Park maintenance staff will repair all identified areas of damage by 8/4/17. 2. The Director of Plan Operations will monitor all areas quarterly on Environment of Care (EOC) rounds to ensure standards are met. 3. The Director of Plan Ops will report out results of the EOC rounds at the Environment of Care Committee quarterly and to the facility-wide PI/QI Committee on a quarterly basis.	8/4/17

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F 253	Continued From page 13 2. Observation of the East wing resident areas on 6/22/17 at 8:45 AM revealed the following issues with building repairs: a. In room #12 the bathroom inner door at the bottom was observed to have a deep scuffed area at 3 inches up and 17 inches across that created a surface which could not be effectively cleaned. b. In room #6 the bathroom floor was observed to have multiple scattered chips in the linoleum that were darkened with dirt and debris. In addition, the bathroom inner door had a 12 inch scuffed area near the bottom that created a surface which could not be effectively cleaned. c. In the hallway by room #14 the wallpaper was observed to have a chipped area which created a surface which could not be effectively cleaned. d. In the hallway by room #11 the wallpaper was observed to be damaged which exposed metal underneath and created a surface which could not be effectively cleaned. 3. Observation of the secure unit resident areas on 6/22/17 at 8:55 AM revealed the following issues with building repairs: a. In room #29 the inner bathroom door was observed to have a scuffed area 3 inches from the bottom and 11 inches across that created an a surface which could not be effectively cleaned. b. In room #25 the floor in front of a chest-of-drawers was observed to have multiple chips and was darkened with dirt and debris in a 33 inch by 11 inch area. c. The hallway outside of room #12 was observed to have a small gouge in the wallpaper which created a surface which could not be effectively cleaned.	F 253		

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F 253	Continued From page 14 d. The hallway across from room #22 was observed to have chipped wallpaper in multiple areas with the largest at 8 inches across that created a surface which could not be effectively cleaned.. e. The hallway outside of room #23 was observed to have the corner of the joining walls damaged which exposed metal for 11 inches and created a surface which could not be effectively cleaned. f. The hallway to the left of room #24 was observed to have 2 scraped areas on the wallpaper that created a surface which could not be effectively cleaned. g. The hallway to the right of room #25 was observed to have a scraped corner 18 inches from the baseboard up that created a surface which could not be effectively cleaned. h. The hallway between rooms #25 and #26 had an unmeasured area where the wallpaper was observed to be coming loose from the wall. i. The celling above the 2 linen carts in the secure area was observed to have 6 celling tiles that were damaged and created a surface which could not be effectively cleaned. 4. Observation of areas outside of the resident rooms and hallways on 6/22/17 at 9 AM revealed the following issues with building repairs: a. The division of the main first floor dining room floor and the hallway outside of the dining room was observed to be uneven 6 feet across. In addition, 6 floor tiles that measured 12 inches by 12 inches were observed with multiple cracks which were darkened with dirt and debris. b. Two clean linen carts in the secure unit were observed to have damaged and torn covers that could not ensure adequate protection of the clean linen.	F 253		

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F 253	Continued From page 15 c. The 2 fire doors on the East Wing across from room #13 was observed to have floor damage with multiple small cracks 6 feet across. 5. On 6/22/17 at 10 AM a tour with the maintenance director revealed he was aware the identified areas were in need of repair and the facility planned to complete those repairs. However, the facility failed to have a plan with a timeframe to complete those repairs.	F 253		
F 309 SS=D	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 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309	The facility will ensure that neurological assessments are completed on any resident situation resulting in him/her hitting head or unwitnessed falls of residents with a diagnosis of dementia. 1. Resident #28 has since discharged home on 6/22/17. 2. Nursing staff will be educated through a series of mandatory staff inservices regarding policies and procedures on Fall Prevention and Alert Charting. This will include emphasis on falls not witnessed and residents with a dementia diagnosis. Staff meetings will occur on 7/26/17 and 7/28/17.	8/4/17

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F 309	Continued From page 16 the comprehensive person-centered care plan, and the residents' goals and preferences. (I) 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, staff interview, and policy and procedure review, the facility failed to ensure neurological assessments were completed as necessary for 1 of 7 sample residents (#28) who experienced falls. The findings were: Review of the admission MDS assessment, dated 4/25/17 showed resident #28 had diagnoses which included non-Alzheimer's dementia. Continued review showed the resident was coded as having short and long term memory problems, unable to complete the interview for mental status, and severely impaired related to cognitive skills and daily decision making. Review of a nurse's note dated 6/10/17 and timed 5:37 AM showed the resident had an unwitnessed fall on 6/10/17. The nurse documented the resident was found sitting on the floor tangled up in his/her bed sheets, had no apparent injury, and was repositioned back in his/her bed. In addition, the note showed vital signs were taken. The physician was notified of the incident at 6 AM. Continued review showed the "LTC Fall Note: Initial" dated 6/10/17 was not completed at the time of the fall. Further review showed the next nurse's note was made on 6/10/17 at 3:37 PM. The note showed the resident was "alert to	F 309	3. The Falls review team meets weekly and will review new resident admissions and current fall reports for accurate charting. 4. Individual staff will be counseled/trained with any review of not meeting standards of alert charting by the SDC, DON, and Nurse Manager. 5. New nursing staff will be educated by the SDC or DON on fall prevention and alert charting prior to assignments on units. 6. DON, Nurse Manager or SDC will do monthly reviews on any falls for assessment and charting accuracy. Compliance goal will be set at 85% or above for three consecutive quarters with periodic observations on an ongoing basis to ensure compliance. 7. Results of the monthly reviews will be reported to the PI/QI Committee quarterly.	

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F 309	Continued From page 17 person and there were no abnormalities in the vital signs." Review of nurses' notes dated 6/10/17 through 6/15/17 and review of the medical record failed to show neurological checks/assessments were completed. Interview with the DON on 6/22/17 at 2 PM confirmed an unwitnessed fall should have had neurological checks implemented according to policy. In addition, she stated sometimes this resident could tell staff what was going on but given his/her cognitive history the fall should have been treated as a fall with head injury. Review of the policy and procedure titled "Prevention of Resident Falls," revised 8/06, showed "...All residents with falls will be fully evaluated to determine need for change in care... 4. If resident falls, nursing will evaluate for other immediate interventions/changes needed for care plan..." Review of the policy titled "Alert Charting," revised 11/2012 showed "...Procedure 1. When a resident experiences a change in physical or mental condition, the nurse initiates the Alert Charting procedure. Below is a list of conditions that trigger placing a resident on Alert Charting ...Falls..." Review of the "Alert Charting Minimum Charting Expectation," not dated, showed ..."Fall, 72 hours-3 days, Charting Expectation, Every shift focus note on fall with vital signs, Interventions Focus Note, Vital Signs every shift (QS)...Fall w/Head Injury, 72 hours-3 days, Charting Expectation, Every shift focus note regarding fall, PLUS Every shift focus note pertaining to Neurological status, Interventions, long term care (LTC) Nursing Assessment, Vitals Signs QS, NEURO MONITORING/GLASGOW SCALE (summation of scores for eye, verbal, and motor responses)."	F 309		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 18 DEPENDENT RESIDENTS (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 medical record review and resident and staff interview, the facility failed to ensure assistance with activities of daily living was provided in a timely manner for 4 of 13 residents (#25, #28, #69, #77) who required bathing assistance. The findings were: 1. Review of the 4/2/17 admission MDS assessment showed resident #25 had diagnoses which included a hip fracture. Continued review showed s/he was totally dependent and required assistance of 1 staff person for bathing. Review of the bath documentation showed the resident had a shower or bath on 5/12/17, 5/19/17, 5/26/17, 5/31/17, 6/5/17, 6/16/17, and 6/20/17. The review showed the resident had no bath or shower after 6/5/17 until 6/16/17 (11 days). 2. Review of the 4/25/17 admission MDS assessment showed resident #28 had diagnoses which included non-Alzheimer's dementia and malnutrition. Continued review showed s/he was totally dependent and required assistance of 2 plus staff members for bathing. Review of the bath documentation showed the resident had a shower or bath on 5/15/17, 5/18/17, 5/22/17, 5/25/17, 6/1/17, 6/12/17, 6/15/17, and 6/19/17. The review showed the resident had no bath or shower after 6/1/17 until 6/12/17 (11 days). 3. Medical record review for resident #69 showed	F 312	The facility will ensure that the residents' activities of daily living involving bathing schedules will be met through individual resident assessments, interviews, and bathing schedules. 1. Resident #28 was discharged from the facility to home on 6/22/17. 2. Resident #25 was reassessed for bathing schedule and preferences and receives two baths weekly. 3. Resident #69 was reassessed for bathing schedule and preferences and receives two baths weekly. 4. Resident #77 was reassessed for bathing schedule and will now receive one shower and one bath per week. 5. All residents will be assessed on admission for bathing preferences and scheduling which will include interview of resident or appropriate responsible member of his/her care.	8/4/17

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F 312	Continued From page 19 s/he had diagnoses which included arthritis. Review of the 4/28/17 annual MDS assessment showed s/he required extensive assistance of 1 staff member for bathing. Review of the bath documentation showed the resident had a shower or bath on 5/23/17, 5/26/17, 5/30/17, 6/2/17, 6/9/17, and 6/20/17. The review showed the resident had no bath or shower after 6/9/17 until 6/20/17 (11 days). Interview with the resident on 6/20/17 at 8:30 AM revealed the resident had not had a bath or shower until 6/20/17 for "about two weeks" and she preferred to have a shower or bath twice a week. 4. Medical record review for resident #77 showed s/he had diagnoses that included rheumatoid arthritis. Review of the 5/12/17 quarterly MDS assessment showed s/he required physical help in part of bathing activity by 1 person. Review of the bath documentation showed the resident had a bath on 5/10/17, 5/19/17, 5/24/17, 5/31/17, 6/7/17, and 6/19/17. The review showed the resident had no bath or shower after 6/7/17 until 6/19/17 (12 days). Interview with the resident on 6/21/17 at 5:30 PM revealed the resident had not had a bath in "12 days." In addition, s/he stated, the bath aide had to work on the floor due to staffing issues and s/he "wasn't notified that s/he was going to be skipped for a bath." Further, the resident stated "it [missed baths] happens frequently." 5. Interview on 6/22/17 at 12:05 PM with the DON revealed the facility had a communication problem when one of the bath aides went on vacation. She stated "there is no excuse for not getting baths."	F 312	6. Bath aides and staff filling in for those staff members, will provide a Monday through Friday list of residents who have and have not received bathing ADL's to the DON or Nursing Manager. 7. The DON or Nurse Manager will address any concerns on bath ADL's and make changes for that resident to meet his/her needs. 8. The results of these records will be reported to the PI/QI Committee on a quarterly basis.	
F 371	483.60(i)(1)-(3) FOOD PROCURE,	F 371		

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F 371 SS=D	Continued From page 20 STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (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 food was prepared under sanitary conditions in 1 of 1 kitchens. The findings were: Observation on 6/19/17 at 3:50 PM and again on 6/20/17 at 3:31 PM showed 8 cutting boards of various sizes and colors were visibly scored, which created a surface that could not be cleaned. Interview with the interim food service director on 6/20/17 at 3:45 PM confirmed the	F 371	The facility will ensure that food is prepared under sanitary conditions utilizing food preparation surfaces that can be cleaned effectively. 1. Cutting boards will be inspected by the Food Service Director (FSD) every month x 3, then every six months or sooner. 2. Eight cutting boards that were visibly scored were resurfaced and there is no visible scoring. 3. The FSD will provide education to dietary staff on assessing cutting boards used and knowing when to replace them. 4. The FSD will continue to monitor the condition of the cutting boards and present the results to the PI/QI Committee quarterly.	7/14/17

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F 371	Continued From page 21 cutting boards were in poor condition and needed to be replaced or resurfaced. According to Food Code 2013, U.S. Public Health Service 4-501.12 "Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED or discarded if they are not capable of being resurfaced."	F 371		
F 387 SS=E	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure residents were seen by a physician at least once every 60 days for 6 of 11 sample residents (#34, #40, #44, #49, #69, #75). The findings were: 1. Review of the medical record for resident #34 showed the resident was seen by a physician on 2/4/17. At the time of the survey 135 days had lapsed since the last documented physician visit. 2. Review of the medical record for resident #40 showed s/he was admitted to the facility on 10/18/16 and was seen by a physician on	F 387	The facility will assure that residents are seen on a timely basis by their physician and mid-level practitioners in accordance to 483.30(c)(1)(2). 1a. Resident #34 is now current with the last physician visit 7/3/17. 1b. Resident #40 is scheduled for a physician visit on 7/17/17. 1c. Resident #44 is current with the last physician visit 7/13/17. 1d. Resident #49 is now current with the last physician visit 6/17/17. 1e. Resident #69 is now current with the last physician visit 7/6/17. 1f. Resident #75 is now current with the last physician visit 5/27/17.	8/4/17

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F 387	Continued From page 22 11/22/16. The resident was seen by a mid-level practitioner on 12/16/16 and again on 4/2/17 (106 days). There was no evidence the resident had been seen by a physician since the 11/22/16 visit. 3. Review of the medical record for resident #44 showed s/he was admitted to the facility on 3/11/17. The resident was seen by a physician on 5/5/17, 55 days later. 4. Medical record review showed resident #49 had a physician visit on 12/16/16. The next physician visit was on 3/1/17 (73 days) with no mid-level practitioner visits between. 5. Medical record review showed resident #69 had a physician visit on 12/16/16. The next physician visit was on 3/1/17 (73 days) with no mid-level practitioner visits between. 6. Medical record review showed resident #75 had a physician visit on 2/1/17. The next physician visit was on 4/24/17 (81 days) with no mid-level practitioner visits between. 7. Interview with the DON on 6/21/17 at 12:05 PM confirmed the physician visits should have been completed more frequently.	F 387	2. All residents will be monitored on a monthly basis to ensure that physician's visits are made timely, and physicians notified via a rounds list of visits that are approaching an overdue date. 3. The facility's Medical Director will be notified of any physician non-compliance with required visits. 4. The timeliness of physicians' visits will be monitored by the Nurse Manager and reported to the facility's PI/QI Committee on a quarterly basis.	
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects	F 428	The facility will assure that a drug regimen review will be conducted for each resident at least once a month by a licensed pharmacist. 1a. April medication review for resident #8 occurred on 5/11/17. 1b. April medication review for resident #25 occurred on 5/15/17.	7/11/17

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F 428	Continued From page 23 brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and	F 428	1c. April medication review for resident #28 occurred on 6/14/17. 1d. April medication review for resident #34 occurred on 5/15/17. 1e. April medication review for resident #44 occurred on 5/15/17. 1f. April medication review for resident #49 occurred on 5/9/17. 1g. April medication review for resident #53 occurred on 5/9/17. 1f. April medication review for resident #69 occurred on 5/10/17. 1g. April medication review for resident #75 occurred on 5/10/17. 2. Monthly monitoring will be completed by the lead pharmacist to ensure that these reviews are completed in a timely manner before the end of the month. 3. The back-up plan will be activated if the reviews are not 100% completed by the 20th of the month. If this is the case, the lead pharmacist or other appointed pharmacist will complete the review within 3 days. 4. The lead pharmacist will sign off on a monthly report of completed medication reviews, which will be reported to the PI/QI Committee quarterly.	

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F 428	Continued From page 24 steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist for 9 of 13 sample residents (#8, #25, #28, #34, #44, #49, #53, #69, #75). The findings were: 1. Review of the medical record for resident #8 revealed s/he did not have a monthly pharmacy medication review for April 2017. 2. Review of the medical record for resident #25 revealed s/he did not have a monthly pharmacy medication review for April 2017. 3. Review of the medical record for resident #28 revealed s/he did not have a monthly pharmacy medication review for April and May 2017. 4. Review of the medical record for resident #34 revealed s/he did not have a monthly pharmacy medication review for April 2017. 5. Review of the medical record for resident #44 revealed s/he did not have a monthly pharmacy medication review for April 2017. 6. Review of the medical record for resident #49 revealed s/he did not have a monthly pharmacy medication review for April 2017. 7. Review of the medical record for resident #53 revealed s/he did not have a monthly pharmacy medication review for April 2017.	F 428		

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F 428	Continued From page 25 8. Review of the medical record for resident #69 revealed s/he did not have a monthly pharmacy medication review for April 2017. 9. Review of the medical record for resident #75 revealed s/he did not have a monthly pharmacy medication review for April 2017. 10. Interview on 6/22/17 at 11:15 AM with the pharmacy director revealed it was his expectation drug regimen reviews be completed on a monthly basis. In addition, he stated the pharmacist had recognized that he had missed the April review due to illness, vacation, and a computer upgrade. 11. Interview on 6/22/17 at 12:05 PM with the DON confirmed the pharmacy medication review had not been done in April. Further, she stated a "back up plan" was needed.	F 428		
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);	F 441	The facility will ensure staff utilize effective infection control practices using gloves, hand sanitizer, and hand washing during all direct resident contact, as well as effective hand hygiene practices while providing meal assistance. 1. A. Focus observations will occur on use of infection control practices during meals involving resident #'s 2, 3, 4 and 8.	8/4/17

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F 441	Continued From page 26 (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; (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	F 441	B. Focus observations will occur on use of gloves with handling catheter bag on resident #8. C. Focus observations will occur on cleaning of the non-mechanical sit-to-stand lift between uses for resident #34 and 38. 2. Nursing staff will be educated through a series of staff meetings/inservices regarding proper cleaning of resident equipment and infection control policy/procedures on hand washing, sanitizing and glove use. Mandatory in-services will be conducted on 7/14/17 and 7/19/17. Ongoing education will occur at least every six months.	

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F 441	Continued From page 27 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 and staff interview, the facility failed to ensure effective hand hygiene practices were followed by staff while providing meal assistance during 2 of 2 meal observations and failed to ensure infection control practices were implemented during 3 random observations. These practices affected residents #2, #3, #4, #8, #34, #38. The findings were: 1. Observation on 6/19/17 at 6:10 PM of the evening meal showed CNA #5 touched multiple residents' wheelchair handles and backs. Further observation showed the CNA fed resident #4 some of his/her dessert; opened resident #3's dessert; touched resident #2's utensils and fed the resident a bite of his/her dinner. At no time did the CNA perform hand hygiene. 2. Observation on 6/20/17 at 8:10 AM showed CNA #6 placed resident #8's catheter bag into a fabric cover and secured the bag to the resident's bed frame using her bare hands. Interview at 8:40 AM with the CNA revealed the facility policy was to wear gloves when handling catheter bags. In addition, she stated, " I should have had gloves on, I saw it [catheter bag] hanging on the bed frame without a cover on it and I didn't want it [catheter bag] to stay like that. I washed my	F 441	2. Nursing staff will be educated through a series of staff meetings/inservices regarding proper cleaning of resident equipment and infection control policy/procedures on hand washing, sanitizing and glove use. Mandatory in-services will be conducted on 7/14/17 and 7/19/17. Ongoing education will occur at least every six months. 3. Nursing staff will be monitored in dining rooms for proper use of hand sanitizer/handwashing between residents. This will involve observation by the Director of Nursing (DON), Staff Development Coordinator (SDC), Infection Control (IC) nurse and/or Registered Dietician (RD). Observation will occur no less than three meals weekly in one of the three dining rooms. The results of these observations will be reported to the PI/QI Committee on a quarterly basis until compliance reaches 90% for three consecutive quarters, with periodic observations on an ongoing basis to ensure sustained compliance.	

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F 441	Continued From page 28 hands immediately after handling the bag." 3. Observation on 6/20/17 at 9:20 AM showed CNA #7 used a sit to stand lift to transfer resident #38 from a wheelchair to a recliner. After the transfer the lift was placed in the hallway. At 9:32 AM the same CNA used the same lift to transfer resident #34 from a wheelchair to a recliner. The lift was again placed in the hallway. The lift was not cleaned between resident uses. Interview with the CNA at 11:40 AM revealed the night shift cleaned the lifts on a daily basis, however, they would clean the lift after use if a resident had an infection. 4. Observation on 6/20/17 at 5:43 PM of the evening meal showed CNA #8 was serving residents. The CNA picked up beverage glasses for two residents before filling them with juice and allowed her fingers to touch the inside surface of the glasses. Further observation showed the CNA used a resident's spoon to remove butter from a container; touched another resident's back and hands; used a third resident's utensils to cut up meatloaf and remove butter from a container and then returned the utensils to the resident. At no time did the CNA perform hand hygiene. The CNA was also observed entering the kitchen on several occasions without donning a hairnet. Interview on 6/20/17 at 6:10 PM with the clinical nutrition director confirmed the expectation was hand hygiene be performed between resident contacts and hairnets needed to be worn when entering the kitchen area. In addition, she stated more education was needed related to infection control in the dining room. 5. Interview with the DON on 6/22/17 at 11:50 AM confirmed the expectation was for staff to use	F 441	4. Observations will be conducted for proper use of cleaning lifts or other resident equipment between residents by the SDC, Nurse Manager, IC nurse or DON for no less than six residents weekly until compliance reaches 90% for three consecutive quarters with periodic observations on an ongoing basis to ensure sustained compliance. 5. The results of these observations will be reported to the PI/QI Committee on a quarterly basis until goals reached. 6. Sani-cloth germicidal disposable wipes or comparative cleaner will be mounted in areas on the East wing, the Special Care Unit (SCU) and additional areas on the 2nd floor, which include both bath houses in order to make them readily available to staff for cleaning equipment. Wall mounted brackets to hold germicidal cloths were ordered 7-13-17. Individual hand sanitizer is made available in each dining room to allow staff the sanitize hands between assisting residents.	

F441
Continued

7. New nursing staff will be educated by SDC or IC nurse on infection control practices involving use of handwashing, sanitizing and gloving. Education will also include cleaning of resident equipment. This will include both written and return demonstration to meet 100% prior to direct contact with residents.

The facility will ensure staff utilize effective infection control practices using gloves, hand sanitizer, and hand washing during all direct resident contact, as well as effective hand hygiene practices while providing meal assistance.

1. A mandatory in-service regarding proper food and service ware handling was provided by nutrition service on 7-14-17.
2. Education on effective hand hygiene and food handling practices during meal service will be provided annually to dietary and nursing staff in long term care.
3. New staff will be educated with this material via the facility online employee orientation education system.
4. The quality indicator/performance improvement plan have been developed to ensure that effective hand hygiene and food/service ware handling is occurring. The results of this monitoring will be reported to the facility's QI/PI Committee on a quarterly basis.
5. The facility will ensure that hairnets are worn when entering the kitchen area according to policy.

F441
Continued

6. Hairnet holders have been ordered and will be placed at both doors entering the 2nd floor LTCC kitchen.
7. Adherence to this policy will be monitored on a weekly basis by the LTCC RD, IC nurse or nurse manager during the meal rounding. No less than three meals per week (at different meal times) will be observed.
8. New dietary staff will be educated by the Food Services Director on infection control practices involving use of handwashing, sanitizing and gloving.
9. New nursing staff will be educated by the SDC or IC nurse on infection control practices involving use of handwashing, sanitizing and gloving.

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F 441	Continued From page 29 disinfectant wipes on lifts between resident use and gloves should be worn when handling catheter bags. Further, hand hygiene was to be performed after handling catheters. In addition, she confirmed staff should never place hands inside of resident drinking glasses and hand hygiene should have been performed any time they touched something, "that's why I placed a bottle of hand sanitizer on each dining table."	F 441		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of	F 520	The facility will assure an effective quality assessment and assurance program by addressing repeat deficient practice from previous surveys. 1. The PI/QI committee met on 7-11-17 to discuss recent citations from the survey and will include the observations for activities practices in the process. In addition, timely physician visits will remain on the agenda for discussion into FY2018. 2. The Administrator and designated staff members will assist with monitoring corrected practices to ensure that they remain compliant. 3. These items will be reported quarterly at the PI/QI committee to assure compliance.	8/1/17

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F 520	Continued From page 30 action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of compliance history information, the facility failed to ensure an effective quality assessment and assurance (QAA) program was implemented to prevent repeat deficient practice (F248, F387) from previous surveys. The findings were: 1. Review of the Casper 3 report last updated on 6/2/17 showed on the 3/2014, 5/2015, and 6/2016 surveys the facility was cited for activities (F248). The facility had corrected the identified deficient practice from the surveys. However, the facility was again cited with non-compliance of this issue on the 6/22/17 survey. Interview on 6/22/17 at 1:17 PM with the administrator and DON revealed activities were not being monitored by the QAA committee. 2. Review of the statement of deficiencies for the 6/23/16 recertification survey showed deficiencies which included frequency of physician visits (F387). Interview on 6/22/17 at 1:17 PM with the administrator and the DON revealed the QAA program continued to collect data related to the	F 520		

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F 520	Continued From page 31 frequency of physician visits, however, problems had continued.	F 520		