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

PRINTED: 08/31/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 08/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 8/14/17 through 8/17/17. Also reviewed in the course of the survey were complaint intakes WY000002408, WY000002422, and WY000002449. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing Services MAR- Medication Administration Record MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F167 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual.	
F 167 SS=D	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 167	1. The form was removed at the time of the survey. The binder was reviewed in its entirety to ensure that no other "confidential for facility use only" forms were inadvertently included in the required postings. 2. All residents identified on the state issued form had the potential to be affected by this deficient practice. 3. The Assistant Administrator was in-serviced on requirements of the regulation on 9/7/17. The Assistant Administrator or designee will complete a monthly audit for 3 months to ensure that the correct documentation is contained in the survey binder. 4. The Assistant Administrator or designee will be responsible to report to the QA committee the findings of the monthly audit	8/17/17 9/7/17 9/30/17

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

Administrator 9/10/17

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 167	Continued From page 1 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect confidential identifying information in regard to resident names in the survey binder which was available for public viewing. The census was 79. The findings were: Observation on 8/16/17 at 1:17 PM of the facility survey activity binder located near the main entrance showed the binder contained the "confidential for facility use only" form which included resident names and their corresponding identification numbers related to the 12/16/16 complaint survey. Interview with the acting administrator on 8/16/17 at 1:40 PM confirmed the presence of this document and at that time the administrator removed it from the binder.	F 167	for review and recommendations. The Assistant Administrator or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached. F253 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual.	
F 253 SS=D	483.10(l)(2) HOUSEKEEPING & MAINTENANCE SERVICES (l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 253	1a. The flooring in the SCU dining room is scheduled to be repaired by September 30, 2017. 1b. On September 6, 2017, the transition strips were repaired in the bathrooms of Rm 104 and Rm 114	9/30/17 9/6/17

9-12-17 4:28 pm P.O.C. accepted between Teresa Ralph, Assistant Administrator and Colleen Hogan, MSN, RN with a D.O.C. 9/30/17
Date of Survey 8/17/17

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F 253	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a safe and sanitary environment in 1 of 3 dining rooms (secure unit dining room) and 1 of 6 hallways (100 hall). The findings were: 1. Observation on 8/15/17 at 5 PM revealed the following concerns in the secure unit dining room. a. Linear cracks extended over 18 of 20 consecutive 12 by 12 inch floor tiles. b. A zigzag gouge in the floor to the right of the south exit door extended over seven 12 by 12 inch floor tiles. c. A crack on the floor near the north entrance to the sunroom spanned the width of a 12 by 12 inch tile. 2. Observation on 8/15/17 at 4:30 PM showed the transition strip leading into the bathroom of room 104 and 114 was missing. 3. Observation and interview with the maintenance manager on 8/17/17 at 8:30 AM confirmed the identified areas needed to be repaired.	F 253	2a. Individuals residing in the secure unit of the facility have the potential to be impacted by this deficient practice. 2b. All residents within the facility have the potential to be impacted by the deficient practice. 3a. The facility Maintenance Director is working with the Regional Facilities Director to identify concerns and needed repairs to the existing floor throughout the facility. Work is being identified and scheduled for repair. The Maintenance Director or designee will complete weekly rounds that identify any new concerns with the facility flooring. 3b. The facility Maintenance Director or designee will complete weekly rounds that identifies any concerns regarding transition strips in resident rooms/bathrooms. 4. The Maintenance Director or designee will be responsible to report to the QA committee findings of the weekly audits for review and recommendations. The Maintenance Director or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17 9/30/17 9/30/17 9/30/17 9/30/17
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	F 272	F272 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by	

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F 272	Continued From page 3 (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by:	F 272	Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1. The CAA's required for cognitive loss/psychosocial well-being, Mood state, and behavioral symptoms were completed via global CAA note and the care plans for residents #31 and #76 were reviewed to ensure accuracy. Revisions to care plans were made as needed. 2. A global CAA note will be written on each resident found to not have completed CAA's in the areas mentioned above. The care plans of the individuals identified will be reviewed to ensure accuracy. 3. Starting September 11, 2017 the Social Services team will be re-trained on the importance of analyzing the data within the content of the CAA in order to draw a conclusion that supports the care planning decision. The MDS Coordinator or designee will be responsible to complete a weekly audit of Social Services triggered CAA's to ensure completion.	9/10/17 9/30/17 9/12/17 9/30/17

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F 272	Continued From page 4 Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 2 of 13 sample residents (#31, #76). The findings were: 1. Review of the 6/26/17 significant change MDS assessment for resident #31 showed areas that triggered for comprehensive assessment included: cognitive loss/dementia, behavioral symptoms, and psychotropic drug use. Review of the CAAs for these triggered areas showed the nature of the problem was not defined and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 2. Review of the 7/25/17 significant change MDS assessment for resident #76 showed areas that triggered for comprehensive assessment included: cognitive loss/dementia, psychosocial well-being, mood state, and behavioral symptoms. Review of the CAAs for these triggered areas showed the problem was not defined and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 3. Interview with the MDS coordinator on 8/16/17 at 3:35 PM verified these CAAs were not comprehensive. She further stated there was training in process related to the completion of MDS assessments.	F 272	4. The MDS Coordinator or designee will be responsible to report to the QA committee findings of the weekly audits for review and recommendations. The MDS Coordinator or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached. F280 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual.	9/30/17
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 5 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280	1. The resident representative will be called on September 11, 2017 and the current plan of care for resident #17 will be reviewed. 2. All residents have the potential to be affected by this deficient practice. 3. The Social Services team was in-serviced on September 7, 2017 on the requirements of this regulation. A care plan letter has been created. This letter will be mailed to the responsible party for the residents or hand delivered to those residents that are self-responsible. A copy of each of these letters will be retained in individual resident files within the Social Services office and/or a note made in the progress notes of the electronic record that the letters were sent/delivered. A weekly audit will be completed to ensure that letters have been sent to appropriate parties for the following weeks scheduled care conferences. 4. The Social Services Director or designee will be responsible to report to the QA committee any concerns with distribution of monthly care plan meeting letters for review and recommendations. The Social Services Director or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/12/17 9/30/17 9/12/17 9/8/17 9/30/17 9/30/17

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F 280	Continued From page 6 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 280		

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F 280	Continued From page 7 Based on medical record review, family and staff interview, the facility failed to facilitate the inclusion of the resident's representative in the care planning process for 1 of 13 sample residents (#17). The findings were: Review of the medical record for resident #17 showed an annual MDS assessment was completed on 3/13/17 and a quarterly MDS assessment was completed on 8/11/17. Further review of the medical record revealed the resident had a BIMS score of 5/15 (severe impairment) and had a family member named as his/her representative. Interview with the resident's representative on 8/15/17 at 7:15 PM revealed s/he had no recollection of attending a meeting with the facility to discuss the plan of care. The following concerns were identified: a. Review of the medical record revealed no evidence the resident's representative was notified of the care plan conference after the assessments were completed. b. Interview with the social service director on 8/16/17 at 11:30 AM revealed he had stopped sending letters to resident representatives with the date and time of the proposed care conference and had started to make direct phone calls. However, review of the medical record revealed no documentation the resident's representative had been contacted in regard to the time and date of the care plan conference. c. Interview on 8/16/17 at 11:40 AM with the consultant RN verified documentation was not in the medical record and interview with the social service director on 8/17/17 at 9:12 AM confirmed there was no further documentation of resident representative notification of care plan conferences available.	F 280		

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F 282 F 282 SS=D	Continued From page 8 483.21(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 staff interview the facility failed ensure the plan of care was followed as written for 1 of 13 sample residents (#17). The findings were: Review of the 8/1/17 quarterly MDS assessment for resident #17 showed the resident required the extensive assistance of one staff member for transfers and toilet use; was always incontinent of bladder and occasionally incontinent of bowel. Review of the care plan in the category of bladder incontinence, last revised 8/15/17, showed an intervention of "assist/check and change PRN (as needed) and when [resident's name] indicates need to use restroom." The following concerns were identified: a. Continuous observation on 8/15/17 from 8:16 AM through 12:35 PM (4 hours and 19 minutes) showed the resident was in the common room of the secure unit seated in a wheelchair. During this timeframe the resident was not offered assistance to the restroom. b. Interview with CNA #1 at 12:35 PM revealed the resident will "usually" tell them when s/he needs the bathroom, however, s/he was resistive to care and often refused.	F 282 F 282	F282 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1. Resident #17's plan of care and Kardex was reviewed and updated to current toileting needs and appropriate interventions. 2. An audit of residents that require staff assistance for transfer and toileting was completed. The care plans and Kardex of each of these individuals will be reviewed to ensure a person centered approach to care and services was included. 3. Education on importance of following individual care plans and Kardex will be provided to the Certified Nursing Assistants starting on September 11, 2017. Daily documented observations of care will be completed for 2 residents requiring assistance with toileting at alternating times for 3 months by the DON or designee to ensure that care plans are being followed or identify if changes to the care plans are needed.	9/10/17 9/30/17 9/30/17

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F 282	Continued From page 9 c. Interview with the MDS coordinator on 8/16/17 at 3:40 PM revealed it was the expectation residents be toileted upon rising, before and after meals, at bedtime and as needed. Further interview verified the resident should have been offered the restroom as care planned.	F 282	4. The Director of Nursing or designee will be responsible to report to the QA committee any findings from observations for review and recommendations. Director of Nursing or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17
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. (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, staff interview, and policy	F 323	F323 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1. The medication cart was locked as soon as it was identified by facility staff. 2. All residents have the potential to be affected by this deficient practice. 3. Nursing staff will be in-serviced and re-educated the need to secure medication carts starting on September 11, 2017.	8/16/17 9/30/17 9/30/17

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	535024	A. BUILDING _____ B. WING _____	C 08/17/2017

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

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F 323	Continued From page 10 and procedure review, the facility failed to ensure a medication cart was maintained in a safe and secure manner during one random observation. The findings were: Observation on 8/16/17 at 2:14 PM showed a medication cart was positioned against a wall next to a chart room in the main lobby of the facility. The top drawer of the medication cart was open approximately 6 inches, and contained bottles of medication that were accessible to passersby. The medication cart had a ringed binder labeled "Hall North & East." There were staff members present in the chart room, but the cart front was facing away from those present. At 2:17 PM LPN #1 walked from a hallway over to the medication cart, closed the drawer and locked it. Interview with LPN #1 at that time revealed she had been using the cart and was called away leaving the drawer open. Review of the policy and procedure entitled "Medication Cart Use" showed "Security: "The medication cart and its storage bins are kept locked until the specified time of medication administration. If an emergency occurs during the medication pass, the nurse securely locks the medication cart before attending to the emergency situation. During routine administration of medications, the cart may be kept in the doorway of the resident's room with: - drawers unlocked and facing inward, and within sight of the nurse - no medications are kept on top of the cart. The cart must be clearly visible to the person administering medications, and all outward sides must be inaccessible to persons passing by." Interview on 8/17/17 at 12:59 PM with the acting	F 323	Starting the week of September 11, 2017, random, weekly audits of medication carts will be completed by the Director of Nursing of designee of the medication carts to ensure ongoing compliance with securing medication carts. 4. The Director of Nursing or designee will be responsible to report to the QA committee any concerns identified in the audits for review and recommendations. The Director of Nursing or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17 9/30/17

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F 323	Continued From page 11 administrator revealed the expectation was for nurses to be conscientious and keep medication carts locked if stepping away.	F 323	F441 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual.	
F 441 SS=D	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	1. The equipment in question was removed from the bedside and cleaned according to manufacturer's recommendations. 2. The facility has replaced all nebulizer masks for all residents with current orders. 3. Nursing staff will be educated starting on September 11, 2017 on the policy and cleaning instructions. Instructions were added to the administration records of those individual's requiring this type of treatment. Nebulizer masks and tubing will be changed and dated weekly by nursing staff. The DON or designee will complete weekly audits for proper storage and cleaning of nebulizer masks and tubing on 3 residents for 3 months to ensure ongoing compliance. 4. The Director of Nursing or designee will be responsible to report to the QA committee	9/17/17 9/15/17 9/30/17 9/30/17

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F 441	Continued From page 12 (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, policy and procedure review, and review of manufacturer's instructions, the facility failed to follow infection prevention standards regarding equipment cleaning for 1 of 2 sample residents with nebulizers (#52). The findings were:	F 441	any findings of weekly audits for review and recommendations. The Director of Nursing or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	

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F 441	Continued From page 13 Observation on 8/15/17 at 9:50 AM showed resident #52 was provided medications which included a liquid medication to be inhaled through the use of a nebulizer mask. The resident's DeVilbiss brand nebulizer was on his/her bedside table. The fully assembled mask was connected to the nebulizer with tubing, and hung from the top drawer of a dresser near the resident's bed. RN #1 took the mask, unscrewed the medication cup, placed the medication fluid in, reassembled the mask and handed it to the resident, then left the room. At 9:54 AM the resident turned on the nebulizer unit and began his/her treatment. At 10:10 AM the resident turned off the nebulizer, removed the mask and placed it so that it rested on the dresser drawer again. Further observation at 11:08 PM showed the nebulizer mask remained in the same place on the dresser, and was noted to have fluid in the medication cup of the mask. Interview on 8/17/17 at 9:18 AM with the DON revealed she wasn't sure how nebulizer equipment cleaning was handled, but stated whatever the policy statement indicated for cleaning the nebulizer equipment would be the expectation. Review of the policy "Respiratory Policy & Procedure", revised 10/1/2013, showed the procedure "...5. Connect the tubing from the small volume nebulizer to the air outlet on the nebulizer compressor. 6. Add medication to the medication cup of the small volume nebulizer. 7. Plug in the nebulizer compressor and turn the on/off switch to the on position. 8. Administer treatment 9. After the treatment is concluded, store the small volume nebulizer in an equipment bag and leave bedside for the next treatment." The policy	F 441		

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F 441	Continued From page 14 showed no evidence of instructions for cleaning the nebulizer mask, medication cup or baffle between uses. Review of the DeVilbiss nebulizer instruction guide showed the following instructions for cleaning: "Warning To prevent possible risk of infection from contaminated medication, cleaning of the nebulizer is recommended after each aerosol treatment. Disinfecting is recommended once a day. Clean After Every use:...2. Disconnect tubing from the air inlet connector and set aside 3. Disassemble mouthpiece or mask from cap. Open nebulizer by turning cap counterclockwise and removing baffle. 4. Wash all items, except tubing, in a warm water/dishwashing detergent solution. Rinse under warm tap water for 30 seconds to remove detergent residue. Allow to air dry...."	F 441		