POC accepted 10/24/12

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

RECEIVED
WY Dept of Health
OCT 12 2012
Healthcare Licensing
Chief Surveyor

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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
	535017	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(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 The following common abbreviations are used throughout this document: CAA Care Area Assessment CNA Certified Nurse Aide DON Director of Nursing MAR Medication Administration Record MDS Minimum Data Set PRN as needed Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide a wheelchair which fit the resident for 1 of 8 sample residents (#9) who utilized a wheelchair. The findings were: Review of an occupational therapy (OT) discharge note dated 6/21/12 showed resident #9 was seen for wheelchair positioning. The note documented that the resident was positioned in a wheelchair with hips and knees at 90 degrees.	F 246	The facility will ensure a resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. 1. For resident #9, the wheelchair noted by surveyors was taken out of service(on 10/01/2012), and replaced by a more appropriate fitting chair. 2. Occupational therapy will conduct a wheelchair overview for all residents. During this time, all wheelchairs will be checked for size, appropriately functioning parts, and fit, 3. Any resident found to have an inadequate wheelchair	10/18/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather McLea | TITLE: Administrator | (X6) DATE: 10/11/12

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.

POC accepted. Message left for Heather McLea, Administrator 10/24/12 @ 1:34pm Janelle Cox, OTRIC

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F 246	Continued From page 1 The note did not mention the width of the wheelchair. Observation of the resident on 9/17/12 at 5:25 PM, 9/18/12 at 8:46 AM, 9/19/12 12:36 PM, and 9/20/12 at 8:10 AM showed the resident was seated in a wheelchair which was too narrow for the resident. Observation from the back of the wheelchair showed the resident's hips were hanging over the edge of the seat on both sides. During an interview on 9/19/12 at 4:20 PM the DON stated OT provided the wheelchair for the resident. She stated that maybe that was the best of the wheelchairs that the OT had to choose from. On 9/19/12 at 4:25 PM, OT #1 stated that she provided the wheelchair for the resident and that it was "the best out of our stock." The OT did confirm that the width of the wheelchair was a factor that should be considered in selecting a wheelchair. According to Radomski and Trombly Latham in "Occupational Therapy for Physical Dysfunction", 6th edition, 2008, "...Seat width: The therapist determines the widest point across the hips and thighs and typically adds a total of 5 cm (2 inches) for adequate clearance on the sides."	F 246	(either in regards to function or size) will have their current wheelchair changed out for a more appropriate one. Wheelchairs will be replaced with current stock. New wheelchairs may be purchased as needed. 4. OT will continue to conduct such workshops once every six months and as needed to ensure adequate follow up 5. The Director of Nursing (DON) will report on wheelchair functioning (as well as requests for budgeting of new purchases) as a part of the QAA meeting. Any skin breakdown potentially related to wheelchairs will be reported on as well.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 medical record review and staff interview, the facility failed to ensure care was provided in accordance with the written plan of	F 282	The facility will ensure the services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. 1. For resident #2: PRN pain medication has not been used since survey, however, should she require PRN medications, processes are in place to ensure follow up on effectiveness.	10/18/12

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F 282	Continued From page 2 care for 1 of 9 sample residents (#2). The findings were: Review of the care plan dated 8/20/12 for resident #2 revealed staff were instructed to "evaluate effectiveness of analgesics." However, review of the August and September 2012 MARs and pain management flowsheets showed the resident received PRN pain medication on 8/6/12, 8/7/12, 8/8/12, 8/9/12, 8/19/12 and 9/4/12. There lacked documentation of the effectiveness of the pain medication following the administration. Review of nursing notes for those days showed the effectiveness of the pain medication was only addressed for 8/8/12. During an interview on 9/19/12 at 2:55 PM, the DON stated nursing staff should be documenting the effectiveness of the PRN pain medication in the MAR and on the pain flowsheets. However, she stated she was aware of issues with the lack of documentation.	F 282	2. To promote accuracy of medication follow up, medication forms have been condensed. 3. Audits will occur from shift to shift with each shift reviewing the MAR to ensure follow up of medications has been completed. 4. The DON willaudit MAR's on a weekly basis Those findings will be reported at QAA for a period of at least six months. 5. An in-service for nurses will be held 10/18/2012	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure pain relief interventions were monitored for effectiveness for 4 of 6 sample residents (#2 #13, #15, #22) who	F 309	The facility will ensure each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. Regarding residents #2, #13, #15, and #22: residents #2 and #22 have not used PRN pain medication,	10/18/12

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F 309	Continued From page 3 required medications to address pain. The findings were: 1. Review of the 8/3/12 admission MDS assessment showed resident #2 received scheduled and PRN pain medications. It was documented the resident experienced occasional pain at a moderate intensity. Review of physician orders showed the resident was ordered Oxycontin 10 milligrams (mg) twice per day routinely and hydrocodone/Tylenol (Norco) 5/325 mg one to two tablets every 4 to 6 hours PRN. Review of the August and September 2012 MARs and pain management flowsheets showed the resident received PRN (as needed) pain medication on 8/6/12, 8/7/12, 8/8/12, 8/9/12, 8/19/12 and 9/4/12. There lacked documentation of the effectiveness of the pain medication following the administration. Review of nursing notes for those days showed the effectiveness of the pain medication was only addressed for 8/8/12. 2. Review of the 2/16/11 annual, 2/17/12 annual, and 8/3/12 quarterly MDS assessments showed resident #13 received PRN pain medications in the last five days of the assessment, or was offered and declined. The review further determined the resident had not had pain during the last five days of the assesements, and no further assessment concerning pain was completed on any of the MDS assessments. Review of physician's orders showed Tylenol 325 mg 2 tablets every four hours and Tylenol #3 1 tablet every three hours were ordered PRN. Review of the resident's June, July, August, and September 2012 MARs showed the resident received Tylenol and Tylenol #3 for pain	F 309	however, should one be needed, processes are in place to ensure appropriate follow up. In fact, resident #22 has required PRN cough suppressant, which was follow up on. Residents #13 and #15 both did require PRN medications, which were followed up on. 2. Audits will occur from shift to shift with each shift reviewing the MAR to ensure follow up of medications has been completed. 3. The DON will audit MAR's on a weekly basis to oversee compliance. Those findings will be reported as a function of QAA for a period of at least six months. 4. An in-service for nurses will be held 10/18/2012 to provide education regarding the above processes.	

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F 309	Continued From page 4	F 309		

frequently. Review of the entire medical record showed the facility failed to evaluate the resident's level of pain for effectiveness after administration of pain medications on 6/9/12, 6/11/12, 6/22/12, 7/13/12, 7/14/12, 7/15/12, 7/16/12, 7/18/12, 7/24/12, 7/26/12, 8/15/12, 8/20/12, 8/21/12, 8/25/12, 8/27/12, 9/9/12, 9/13/12, 9/14/12, 9/15/12, 9/16/12, and 9/17/12.

3. Review of the 4/16/12 significant change MDS assessment showed resident #15 had a recent hip fracture from a fall. Further review showed the resident had pain during the last five days of the assessment. The assessment showed the resident was unable to answer pain related questions. The assessment showed the following was identified as possible indicators of pain in the last five days: non-verbal sounds, vocal complaints of pain, facial expressions, and protective body movements or postures. Review of the corresponding CAA for pain showed the resident had pain as a result of his/her hip fracture. The assessment also stated the following, "Plan of care is to administer medication as ordered and monitor for effectiveness or adverse side effects." Review of physician's orders showed the resident had the following pain medications ordered PRN: Hydrocodone 5/325 mg (combination analgesic with narcotic) 1 tablet four times per day and Tylenol 325 mg 2 tablets every four hours. Review of the resident's June and July 2012 MAR showed s/he received hydrocodone/apap and Tylenol for pain frequently. Review of the entire medical record showed the facility failed to assess the resident for effectiveness of pain medication administration on 6/2/12, 6/3/12, 6/5/12, 6/6/12, 6/8/12 either time, 6/10/12,

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F 309	Continued From page 5 6/17/12, 6/22/12, 6/22/12, 6/23/12, 6/24/12, 6/25/12, 6/26/12, 6/27/12, 6/29/12, 7/3/12, 7/5/12, 7/7/12, and 7/8/12. 4. Review of the 8/28/12 annual MDS assessment showed resident #22 received PRN pain medications. It was documented the resident experienced occasional pain at a moderate intensity. Review of the physician orders showed the resident was ordered Tylenol 325 mg 2 tablets by mouth every 4 hours as needed. Review of the August and September 2012 MARs and Pain Management Flow Sheets showed the resident received PRN pain medication on 8/1/12, 8/10/12, 8/19/12, 8/20/12, 8/24/12, 9/9/12, and 9/10/12. There lacked documentation of the effectiveness of the pain medication following the administration. Review of the nurses' notes for those days showed the effectiveness of the pain medication following administration was not documented. 5. During an interview on 9/19/12 at 2:55 PM, the DON stated nursing staff should be documenting the effectiveness of the PRN pain medication in the MAR and on the pain flowsheets. However, she stated she was aware of issues with the lack of documentation.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	Based on the comprehensive assessment of a resident, the facility will ensure that a resident who enters the facility without	10/4/12

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F 314	Continued From page 6 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and staff interview; the facility failed to implement interventions to prevent pressure ulcers in 2 of 8 sample residents (#9 and #27) identified as high risk for pressure ulcer development. The findings were: 1. Review of the 6/3/11 quarterly, 6/7/11 significant change, and 9/6/12 annual minimum data set (MDS) assessments for resident #27 showed the resident was identified at risk for pressure ulcers and was also incontinent of urine from occasionally to frequently. Review of the quarterly Pressure Ulcer Risk Evaluations dated 2/16/12, 5/14/12, and 9/14/12 confirmed the resident had been identified high risk with a consistent score of 15 (scale: 2-4 low risk, 5-11 moderate risk, 12 or above high risk). Observation on 9/17/12 at 5:15 PM showed the resident in his/her wheelchair with no seat cushion. Observation of incontinence care on 9/17/12 at 5:30 PM revealed the resident had a small skin tear (1-2 cm in length) below the coccyx in the fold of the buttocks and overall redness over the entire coccyx area. Continuous observation on 9/18/12 showed the resident was in the wheelchair from 9 AM to 10:30 AM (1 ½ hours). Interview with CNA #1 on 9/19/12 at 10:30 AM revealed the resident never had a seat cushion and estimated the resident was in the wheelchair for "probably 3 hours total a day on the day shift" (6 AM to 2 PM). Interview with the	F 314	pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. Resident #27: had a cushion placed in her chair on 10/01/2012 with expressed improvement in comfort. 2. Resident #9: Has a cushion in the new chair noted above. 3. During the month of October, occupational therapy will conduct a wheelchair overview for all residents. During this time, all wheelchairs assigned to those residents who score high for risk of pressure ulcer development will be screened for appropriate cushions in their chairs. Residents will be determined to be at elevated risk if their quarterly evaluation score is elevated (per Pressure Ulcer Risk Evaluation tool which is filled out quarterly). Residents will also be considered elevated risk if they have a current or recently healed pressure ulcer.	

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F 314	Continued From page 7 MDS coordinator on 9/19/12 at 12:40 PM confirmed the facility "never considered a cushion for the resident 's wheelchair" but thought "it's a good idea." 2. Review of the 11/4/11 annual MDS assessment showed resident #9 was at risk for pressure ulcers. The CAA for pressure ulcers documented the resident was at risk due to limited mobility. Review of the Pressure Ulcer Risk Evaluations dated 1/15/12, 4/17/12 and 7/21/12 showed the resident scored "17", at high risk (scale: 2-4 low risk, 5-11 moderate risk, 12 or above high risk). Review of an occupational therapy (OT) discharge note dated 6/21/12 showed the resident was positioned in a wheelchair with a wedge cushion. The following concerns were identified: a. Random observation during the survey from 9/17/12 through 9/20/12 showed no cushion in the resident's wheelchair. Observation on 9/18/12 at 8:45 AM showed the resident remained in the wheelchair during the meal. At 9:45 AM (one hour later) the resident was still seated in the wheelchair. On 9/20/12 at 8:10 AM the resident was seated in the TV lounge in the wheelchair. At 8:25 AM the resident was taken to the dining room for the meal; s/he remained in the wheelchair. b. During an interview on 9/19/12 at 2:30 PM, CNA #1 stated the resident no longer had a cushion when in the wheelchair. She stated the resident remained in the wheelchair during meals. c. On 9/19/12 at 4:25 PM, OT #1 stated she placed a cushion in the resident's wheelchair when she evaluated the resident for positioning. d. During an interview on 9/19/12 at 4:30 PM, the DON stated they removed the cushion from	F 314	4. Any resident found to have inadequate cushioning (either in regards to function or size) will have their wheelchair cushion replaced (or new one placed, as appropriate). 5. Current facility stock will be utilized with new wheelchair cushions purchased as needed. 6. OT will continue to conduct such workshops once every six months and as needed to ensure adequate follow up. 7. The DON will report on OT findings as a function of QAA for a period of at least one year.	

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F 314	Continued From page 8 the wheelchair last week. She stated the resident could no longer transfer to a dining room chair, and the resident was too high in the wheelchair with the cushion. When asked if the facility usually provided a cushion for residents identified as high risk for pressure ulcers she stated "no." She stated certain residents who spent the majority of their time in wheelchairs would have cushions, but other residents may not. 3. According to the National Pressure Ulcer Advisory Panel (NPUAP), "place at-risk persons on pressure-reducing mattress and chair cushion surfaces." Retrieved from www.npuap.org <http://www.npuap.org>, 9/24/12	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's guidelines, and staff interview, the facility failed to ensure one of one blanket warmers was monitored to ensure resident safety. The findings were: Intermittent observations from 9/17/12 through 9/20/12 revealed that blankets were removed from the warmer and placed on residents in the	F 323	The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. The facility Director of Maintenance (DOM) removed the blanket warmer from the facility and repaired the thermostat in accordance with manufacturer guidelines 2. The DOM will log daily blanket warmer temperatures to ensure they do not exceed the upper limit of the manufacturer's guideline of 110 degrees.	10/4/12

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F 323	Continued From page 9 dining room, TV room, activity room, hallways, and patient rooms. Observation of the LED screen on the blanket warmer revealed the following information: a. 9/17/12 at 4:05 PM the temperature on the blanket warmer was 138°F. Subsequent observations the same day at 5 PM and 5:20 PM showed readings of 130°F and 135°F respectively. b. 9/18/12 at 8:15 AM the temperature on the blanket warmer was 145°F. Manual touch at that time showed that the blankets and neck collars on the top shelf were noticeably warmer than the blankets on the bottom shelf. c. 9/19/12 at 10 AM the temperature on the blanket warmer was 159°F. d. 9/20/12 at 8:50 AM the temperature on the blanket warmer was 157°F. e. At the time of each temperature observation, the temperature reading would alternately flash with the letter code of "HA". A thermometer placed in the top shelf between the blankets and neck collars at 9 AM on 9/20/12 revealed a temperature of 150°F. During an interview with the housekeeping supervisor on 9/20/12 at 8:05 AM, he stated the maintenance department was responsible for monitoring the blanket warmer. During an interview with the maintenance supervisor on 9/20/12 at 8:15 AM he stated the housekeeping director had the manufacturer's guidelines for the blanket warmer and was responsible for any monitoring. At 8:35 AM on 9/20/12 a follow up interview with both the housekeeping and maintenance directors confirmed that neither was	F 323	3. The Administrator will monitor the daily blanket warmer temperature log on a weekly basis to oversee compliance and will report findings as a function of QAA for a period of at least 6 months.	

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F 323	Continued From page 10 aware of the high/low limits for the blanket warmer and there was no record of any previous temperature monitoring. Both stated they thought nursing was monitoring the temperatures. Interview with LPN #1 on 9/20/12 at 8:50 AM revealed nursing did not monitor temperatures or change the control setting. The LPN stated that this was done by housekeeping or maintenance. Review on 9/20/12 at 8:35 AM of the manufacturer's guidelines defined the high upper limit for the blanket warmer was 110 degrees and the "HA" code was the indicator for high temperature alarm. According to HcPro, there should be " research of recommended (manufacturer) temperatures . . . develop a policy for blanket and fluid temperatures . . . post the temperature range on all blanket warmers and instruct staff members on the procedure." Retrieved from www.hcpro.com <http://www.hcpro.com> 9/21/12.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	The facility will ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs	10/4/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536017	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(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 329	Continued From page 11 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary drugs for 3 of 9 sample residents (#2, #13, #15). The findings were: Concerns related to adequate indication for use: 1. Review of the admission orders dated 7/26/12 for resident #2 showed an order for Zolpidem (Ambien) 5 milligrams (mg) at bedtime as needed for insomnia. Review of the July 2012 MAR showed the resident did not receive any doses of Ambien. The following concerns were identified: a. Review of the August 2012 physician's recapitulation of orders (signed by the physician 8/2/12) showed the Ambien was now ordered every night at bedtime; not as needed. Review of physician progress notes and telephone orders showed no justification to why the Ambien was now routine. Review of the August and September 2012 MARs showed the resident received the Ambien every night. During an	F 329	1. Resident #2 was given Ambien at HS every day during the month of September 2012. This was due to an error in transcribing the order. This has been corrected and the MAR now says PRN for this medication. 2. Resident #2 did not have a sleep study completed. This assess is done with each quarterly review who triggers Hypnotic medication on the MDS. Correction of this issue will be that any admit MDS d one where Hypnotic medication triggers, the MDS Coordinator will complete the sleep assessment form with the admit MDS. 3. Resident #13 & #15 both received antianxiety medications without appropriate follow-up.	

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F 329	Continued From page 12	F 329		

interview on 9/20/12 at 8:30 AM, the MDS coordinator stated she entered the Ambien wrong in the computer. She stated it was ordered PRN (as needed), but she mistakenly did not enter it as PRN in the computer.

b. Further review of the medical record showed no comprehensive assessment for sleep to determine potential causative factors for the insomnia, nor what non-pharmacological interventions had been tried. On 9/19/12 at 10 AM the MDS coordinator confirmed there was no sleep assessment.

Concerns related to adequate monitoring:

1. Review of the medical record for resident #13 showed s/he had diagnoses which included anxiety disorder. Review of the resident's August 2012 recapitulation of orders showed s/he had a 12/6/11 physician's order for Ativan (anti-anxiety) as needed. Review of the resident's June, July, August, and September 2012 MARs showed the resident received Ativan frequently. Review of the resident's July 2012 Psychoactive Medication Monthly Flow Record (the only month represented) showed the facility documented once per shift for the behaviors and side effects of increased anxiety, lethargy, sedation, and hangover effect. The once per shift documentation did not have a documented time, and a relationship between the assessment and medication administration times could not be established. The documentation further showed these behaviors and side effects were never present during the assessement. The facility failed to assess the effectiveness after the resident received Ativan on 6/2/12, 6/8/12, 6/9/12, 6/13/12, 6/30/12, 7/7/12, 7/14/12, 7/18/12,

4. At the time of survey, the facility had a form on which to document behaviors, but no place to document time or any follow-up. To provide this information, nurses will now document time, behaviors, and follow-up on the PRN sheet with each resident's MAR.

5. Audits will be done from shift to shift with each shift reviewing the MAR to ensure follow-up of medications has been completed.
6. The DON or her designee will audit MAR's on a weekly basis to oversee compliance. Those findings will be reported as a function of QAA for a period of at least six months.
7. An in-service for nurses will be held 10/18/2012 to provide education regarding the above process.

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F 329	Continued From page 13 7/26/12, 8/14/12, 8/20/12, 8/25/12, 8/26/12, 9/9/12, 9/11/12, 9/12/12, 9/14/12, and 9/15/12. 2. Review of the medical record for resident #15 showed s/he had diagnoses which included anxiety state. Review of the resident's August 2012 recapitulation of orders showed s/he had a 4/5/12 physician's order for Ativan as needed. Review of the resident's June, July, August, and September 2012 MARs showed the resident received Ativan frequently. Review of the resident's July 2012 Psychoactive Medication Monthly Flow Record (the only month represented) showed the facility documented once per shift for the behaviors and side effects of increased anxiety, lethargy, sedation, and drowsiness. The once per shift documentation did not have a documented time, and a relationship between the assessment and medication administration times could not be established. The documentation further showed these behaviors and side effects were never present during the assessement. The facility failed to assess the effectiveness after the resident received Ativan on 6/1/12, 6/5/12, 6/9/12, 6/13/12, 6/30/12, 7/7/12, 7/14/12, 7/18/12, 7/28/12, 8/14/12, 8/20/12, 8/25/12 three times, 8/26/12, 9/10/12, 9/13/12, 9/14/12, and 9/15/12. 3. During an interview with the DON on 9/19/12 at 2:55 PM, she confirmed the facility should evaluate the effectiveness of all administered PRN medications, but acknowledged staff frequently failed to do so.	F 329		