| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br><br>ADLs: Activities of Daily Living<br>CAA: Care Area Assessment<br>CNA: Certified Nursing Assistant<br>DON: Director of Nursing<br>MDS: Minimum Data Set<br><br>Less commonly use abbreviations will be annotated in each deficiency where used. | F 000 | | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to provide adequate social services interventions concerning 2 of 2 residents (#14, #18) who required those services. The findings were:<br><br>1. Review of the medical record for resident #14 showed s/he had diagnoses which included chronic obstructive pulmonary disease, congestive heart failure, and depression. Review of the resident's 7/2/13 quarterly MDS assessment showed the resident did not ambulate or propel using a wheelchair on or off of | F 250 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan VanBeek | TITLE: CEO/Administrator | (X6) DATE: 9-16-13

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.



DJW - See Page 2

9/24/13

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| F 250 | Continued From page 1<br>the unit in which s/he resided. During an interview with the resident on 8/19/13 at 4:30 PM, s/he stated that prior to being admitted to the facility, s/he had a motorized scooter for mobility. The resident stated the facility physician had discussed obtaining a motorized vehicle with him/her, and was going to discuss it with the resident's spouse. The resident also stated that s/he would get out of the room if s/he was allowed to have a scooter. The following concerns were identified:<br>a. During an interview on 8/19/13 at 4:30 PM, the resident stated s/he was told by an unidentified staff member the scooter s/he had at his/her spouse's home was too big for the facility. The resident stated the scooter was the same size as other scooters residents were using at the facility. The resident also said the staff member stated there were already too many scooters and electric wheelchairs in the facility.<br>b. Review of a 5/20/13 physician progress note revealed the following, "[The resident] is asking about getting out of the facility a little bit more. [The resident] is getting bored and does not like being stuck inside. [The resident] does have an electric scooter that [the resident] has already but that is not something [the resident] can use in the facility, even outside, because there is no place to store it safely. [The resident] could, however, use a motorized wheelchair if [the resident] was able to obtain one. I will discuss that with [the resident] and [the resident's] family further and see if we cannot get something like that for [the resident] to get outside as the weather improves." During an interview with the resident on 8/19/13 at 4:30 PM, s/he stated that no one had gotten back with him/her about obtaining a scooter.<br>c. During an interview with the social services | F 250 | **F250**<br>A meeting will be set up with Resident #14, the resident's family, the resident's physician and the IDT team to discuss Resident #14s access to an electric wheelchair. Social Services Designee (SSD) will help family (as needed) find the appropriate resources.<br><br>Resident #18 was given a hearing amplifier the first part of August by a friend and does not want a hearing aide at this time. SSD has spoken with the family and resident and will be available to help them if they wish any changes.<br><br>Physicians were reminded of the need to include SSD consult requests in their orders as well as in their dictations. SSD will keep a local Resource List available.<br><br>To assure that all Physician requests for SSD consults are being received, the SSD will complete weekly chart checks for 2 months; bi-weekly checks for 2 months and then monthly checks for one year. SSD will report quarterly to the QAPI committee for one year or until committee recommends completion. | 10-05-13 |



9/24/13 This POC approved between Jan Van Beek (Administrator) and Tony Madden, Surveyor with agreed to changes

QMB 9-16-13

9/24/13

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| F 250 | Continued From page 2<br>director on 8/21/13 at 2:30 PM, she stated she had discussed the resident's scooter with the spouse, and the spouse had stated the scooter was not appropriate for the facility. However, they did not discuss any alternatives such as family providing alternative assistance, or pursuing charitable assistance. She further stated the facility failed to formulate a plan to assist the resident any further to obtain electric transportation.<br>d. Review of the undated facility policy and procedure titled, "Motorized Vehicle Usage", the policy showed, "Crook County Medical Services District strives to promote independence in all residents, including locomotion skills." Review of the procedure included, "Motorized vehicles (electric wheelchairs, scooters, etc.) will not be provided by the facility, but the resident/family may provide if they so wish and the resident meets the criteria."<br><br>2. Review of the medical record for resident #18 showed s/he had diagnoses which included hearing loss. Review of a 6/17/13 nursing note timed at 8 AM revealed the resident reported s/he could not find his/her hearing aids. During an observation on 8/22/13 at 7:45 AM the resident did not have hearing aids in. The following concerns were noted:<br>a. During an interview with the resident on 8/22/13 at 7:45 AM, s/he stated s/he would like to have his/her hearing aids back.<br>b. Review of a 7/22/13 physician progress note revealed the following, "2. Loss of hearing aids. [The resident] is not in a great position to replace those. However, there are some relatively inexpensive hearing aids and possible very low cost replacements through the Lion's Club Hearing Project or through Sound World | F 250 | JMB 4-16-13 | |



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| F 250 | Continued From page 3<br>Solutions."<br>c. During an interview with the social services director on 8/22/13 at 8:10 AM, she confirmed the facility failed to formulate a plan to assist the resident in getting any hearing aid replacements. | F 250 | | |
| F 272 SS=E | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and | F 272 | | |

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| F 272 | Continued From page 4<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview and review of the MDS requirements, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 5 of 6 sample residents (#4, #6, #14, #16, #20) reviewed with comprehensive assessments. The findings were:<br><br>1. Review of the 9/28/12 admission MDS assessment, section V, for resident #4 showed the following areas triggered: cognitive loss, communication, urinary incontinence/indwelling catheter, psychosocial well being, activities, nutritional status, dental care, and pressure ulcers. Review of the corresponding CAAs showed the facility failed to complete a comprehensive assessment to include analysis of findings and only restated the data that was in the MDS assessment.<br><br>2. Review of the 1/15/13 annual MDS assessment, section V, for resident #6 showed s/he required comprehensive assessments in areas which included communication, dehydration, psychotropic drug use, mood, and pain. Section V only showed the MDS assessment as the location of the documentation used to develop the CAAs. Further, the section was not signed and dated to show who the RN | F 272 | F272<br>Minimum Data Set (MDS) Coordinator will provide a comprehensive assessment to include analysis of findings for each corresponding CAA and make sure that all sections on the MDS that are triggered are addressed, signed and dated for Residents #4, #6, #14, #16 and #20.<br><br>Comprehensive Assessments, to include the cause and impact on the resident, will be completed at the time of each resident's MDS on at least a quarterly basis.<br><br>The Assistant Director of Nursing (ADON)/Director of Nursing (DON) will monitor MDSs as they are scheduled to be completed weekly at the IDT meeting, for completeness, an analysis of findings and their impact on the resident, as well as making sure that all triggered sections are addressed and signed and dated.<br><br>The ADON/DON will report quarterly to the QAPI committee on a quarterly basis for one year or until the committee recommends completion. | 10-05-13 |



OMB 9-16-13

9/11/13

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| F 272 | Continued From page 5<br>coordinator for the CAA process was or the person completing the care plan decisions. In addition, review of the CAAs showed the facility failed to identify the cause and impact on the resident in those areas.<br><br>3. Review of the 4/9/13 annual MDS assessment, section V, for resident #14 showed the following areas triggered: cognitive loss, communication, ADL functional/rehabilitation potential, psychosocial well being, activities, pressure ulcers, and psychotropic drug use. Review of the corresponding CAAs showed the facility failed to complete a comprehensive assessment to include analysis of findings and only restated the data that was in the MDS assessment.<br><br>4. Review of the 2/6/13 annual MDS assessment, section V, for resident #16 showed s/he required comprehensive assessments in areas which included delirium, dementia, mood, falls and psychotropic drug use. Section V did not show the location of where the information related to the CAA could be found. In addition, the section was not signed and dated to show who the RN coordinator for the CAA process was or the person completing the care plan decisions. Review of section V showed delirium had triggered and was not care planned. Review of the CAAs showed there was no rational given for not care planning. Further review of the CAAs showed the facility failed to identify the cause and impact on the resident in those areas.<br><br>5. Review of the 4/30/13 admission MDS assessment, section V, for resident #20 showed the following areas triggered: cognitive loss, ADL functional/rehabilitation potential, psychosocial well being, falls, nutritional status, pressure | F 272 | | |

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| F 272 | Continued From page 6<br>ulcers, pain, and return to community/referral. The review showed the facility failed to sign or date section V, which was required. Review of the corresponding care area assessments showed the facility failed to complete a comprehensive assessment to include analysis of findings, and only restated the data that was in the MDS assessment.<br><br>An interview with the MDS coordinator on 8/22/13 at 12:30 PM acknowledged she had unintentionally missed signing section V of the MDS assessments. She revealed she referred primarily to the MDS assessment for the development of the CAAs. | F 272 | **F276**<br>Resident #20's MDS was completed. | |
| F 276 SS=D | 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS<br><br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure that quarterly MDS assessments were completed in the required timeframe for 1 of 6 sample residents (#20). The findings were:<br><br>Review of the admission MDS assessment for resident #20 showed it was completed on 4/30/13. Review of the following quarterly MDS assessment showed it was completed on 8/21/13, 113 days later (required no less than every 3 months). During an interview with the | F 276 | The facility will implement an EHR on October 1, 2013 that has an automatic MDS scheduler to assure that all Resident's receive a timely MDS assessment.<br><br>MDS Coordinator will check the Resident MDS Date list on a weekly basis to assure that all residents have a MDS assessment at least quarterly.<br><br>MDS Coordinator will report to QAPI on a quarterly basis for one year or until the committee recommends completion. | 10-05-13 |



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| F 276 | Continued From page 7<br>MDS coordinator on 8/22/13 at 12:45 PM, she confirmed she was behind on some MDS assessments. | F 276 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to maintain professional standards of practice related to clarification/following physician orders for 1 of 10 sample residents (#16). The findings were:<br><br>Review of the medical record for resident #16 showed s/he had diagnoses to include cardiomegaly (enlarged heart) and anemia. Review of the 7/17/13 physician orders showed the resident was to have his/her oxygen saturations checked every 4 hours during the night. The resident's oxygen saturations were to be maintained above 90% (percent). The staff was to administer oxygen if the resident's saturation levels fell below the ordered parameters. The following concerns were identified:<br>a. Review of the Vital Signs and Weight Record and nurses' notes for July 2013 showed the resident's oxygen saturations were checked only 7 of the 31 days. On those days the resident's saturations were checked, s/he had saturations below the ordered parameters 4 times and was treated with oxygen on 1 occasion.<br>b. Review of the recorded vital signs and | F 281 | **F281**<br>Resident #16's Primary Physician clarified the oxygen and vital sign orders and all extra orders were discontinued and noted by the ADON. The ADON updated the Vital sign/Weight Record to include a place to write Corrective Actions. The ADON will in-service the nursing staff on its use.<br><br>The Night Nurse will conduct a daily check on Physician Orders to assure new orders are followed and any duplicate or conflicting orders are clarified and discontinued as needed.<br><br>ADON/DON will check Physician Orders weekly for one month; every two weeks for one month and then monthly for one year to assure accuracy.<br><br>ADON/DON will report to QAPI on a quarterly basis for one year or until the committee recommends completion. | 10-05-13 |



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| F 281 | Continued From page 8<br>nurses notes for August 2013 showed the resident's oxygen saturations were checked 3 times from 8/1/13 through 8/20/13 (20 days/40 ordered times). Of those days the saturations were checked, the resident showed s/he had saturations below the ordered parameters each time. Further, the documentation did not show treatment with oxygen was provided as ordered.<br>c. Interview with the DON on 8/22/13 at 11:20 AM she acknowledged the staff needed to follow the physician orders for oxygen therapy. Further, the nursing staff needed to clarify the current order to determine if he wanted the resident's oxygen saturations to be checked through the night every 4 hours. | F 281 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, staff interview and review of the facility's policies and procedures, the facility failed to ensure residents received assistance with incontinence care for 2 of 4 residents observed (#19, #13). The findings were:<br><br>1. Review of the medical record for resident #19 showed s/he had diagnoses to include Alzheimer's disease and hip fracture. Review of the 8/14/13 quarterly MDS assessment showed | F 312 | | |

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| F 312 | Continued From page 9<br>s/he needed extensive assistance with toilet use and was totally dependent on staff for personal hygiene. Observation on 8/20/13 at 11:35 PM showed the resident was incontinent of urine. CNA #1 removed the wet incontinence pad and wiped the resident's perineum and left thigh while standing behind the resident, reaching between his/her legs. The CNA did not cleanse the resident's lower abdomen and right thigh where urine would have come in contact with the skin.<br><br>2. Review of the 8/26/13 admission MDS assessment for resident #13 showed s/he needed extensive assistance with toilet use. An observation on 8/19/13 at 5 PM showed the resident was transferred from his/her wheelchair to the toilet with the use of a full lift by CNA #2 and CNA #1. The wet incontinence pad was removed while the resident was in the lift. Incontinence care was performed by CNA #2. She cleansed the resident's posterior perineum area and reached between the resident's legs to cleanse his/her anterior perineum. The CNA did not cleanse the upper thighs and lower abdomen where urine would have come in contact with the resident's skin.<br><br>3. An interview with CNA#3 and CNA #4 on 8/22/13 at 9:25 AM confirmed while providing incontinence care, the resident's lower abdomen, thighs, back and any other areas of the resident's skin that may have come in contact with urine needed to be cleansed.<br><br>4. Review of the policy and procedure entitled, Care for the Incontinent Resident, last revised 6/12/08, showed; "PROCEDURE: ...6. Using tissue or disposable wipes, wipe away as much feces and urine as possible. Then wash the area | F 312 | **F312**<br>All residents receiving assistance with incontinence care will have any area that may have come in contact with urine or feces cleansed, to include the front and back areas from the lower abdomen to the upper thigh.<br><br>ADON/DON will assure all staff is in-services on the correct procedure for providing incontinence cares.<br><br>All CNAs will be observed on a weekly basis (based on schedule) for one month and then monthly for one year to assure compliance with procedure.<br><br>ADON/DON will report to QAPI on a quarterly basis for one year or until the committee recommends completion.<br><br>9-16-13 | 10-05-13 |



9/17/13

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| F 312 | Continued From page 10<br>that has urine or feces on it very well, removing all waste material from the skin..." | F 312 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation and resident and staff interviews, the facility failed to ensure the safety of 1 of 1 sample residents (#19) who was observed wandering. The findings were:<br><br>Medical record review for resident #19 showed s/he had diagnoses to include Alzheimer's disease. Review of the 8/14/13 quarterly MDS assessment, section C showed his/her cognitive skills for daily decision making were severely impaired. Section E showed the resident displayed both physical and verbal behaviors toward others. The following concerns were identified:<br><br>a. During an observation on 8/20/13 at 8:50 AM showed the resident, while in his/her wheel chair, wandered into resident room #204 and was immediately removed from the room by the housekeeping staff. At 9:13 AM the resident returned to the same room, removed the blanket | F 323 | 9/16/13 | |



9/24/13

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|---|---|---|---|
| | 535029 | A. BUILDING _____ B. WING _____ | 08/22/2013 |

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| CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE | 713 OAK STREET SUNDANCE, WY 82729 |

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| F 323 | Continued From page 11<br>from the bed and was observed maneuvering him/herself from the foot of the bed to the side of the bed. At 9:17 AM, 4 minutes later, s/he was again removed from the resident's room. At that time this surveyor observed pill bottles were sitting on the bedside table where the resident had positioned his/herself next to. There were no other residents in the room at the time of the observation.<br>b. At 9:30 AM that same day showed the resident had independently wandered into the unoccupied activity room. The resident became wedged between a large plastic ball and the desk. Staff came into the room to remove the resident. At the time of the observation this surveyor observed 4 scissors, and a potato peeler located on the desk in the activity room. During random observations on 8/20/13 and 8/21/13, the door to activity room remained open.<br>c. Continued observations showed the resident attempted to open doors to resident rooms and wandered into resident rooms #206 and #210. During a confidential meeting with 6 residents on 8/21/13 at 2 PM revealed the resident had wandered into their rooms removing items from the beds. S/he was caught going through dresser drawers located in the resident rooms.<br>d. An interview with the DON on 8/21/13 at 4:30 PM acknowledged the resident was capable of removing the scissors from the desk in the activity room and reaching the resident's medications in room #204. Further, the door to the activity room needed to remain closed and the medications located in room #204 needed to be secured and kept out of reach of the resident. | F 323 | **F323**<br>Resident room #204 was provided with a plastic container that closes securely.<br><br>All doors to the Activities office and shower room are to be kept closed when no one is in attendance. Mesh/Velcro safety banners will be put (as needed) in the doorways of resident rooms to deter wandering residents.<br><br>Activities Director will monitor wandering resident(s) and the effectiveness of the interventions.<br><br>Activities Director will report to QAPI on a quarterly basis for one year or until the committee recommends completion. | 10-5-13 |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS | F 328 | | |

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| F 328 | Continued From page 12<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure residents were monitored and treated for low oxygen saturation levels for 1 of 3 sample residents (#16) with oxygen. The findings were:<br><br>Review of the medical record for resident #16 showed s/he had diagnoses to include cardiomegaly (enlarged heart) and anemia. Review of the 7/17/13 physician orders showed the resident was to have his/her oxygen saturations checked every 4 hours during the night. The resident's oxygen saturations were to be maintained above 90% (percent). The staff was to administer oxygen if the resident's saturation levels fell below the ordered parameters. The following concerns were identified:<br><br>a. Review of the Vital Signs and Weight Record and nurses notes for July 2013 showed the resident's oxygen saturations were checked only 7 of the 31 days. In additon, the times of | F 328 | **F328**<br>Resident #16's Primary Physician clarified the oxygen and vital sign orders and all extra orders were discontinued and noted by the ADON. The ADON updated the Vital sign/Weight Record to include a place to write Corrective Actions. The ADON will in-service the nursing staff on its use.<br><br>The Night Nurse will conduct a daily check on Physician Orders to assure new orders are followed and any duplicate or conflicting orders are clarified and discontinued as needed.<br><br>ADON/DON will check Physician Orders weekly for one month; every two weeks for one month and then monthly for one year to assure accuracy.<br><br>ADON/DON will report to QAPI on a quarterly basis for one year or until the committee recommends completion.<br><br>GMB 9/6/13 | 10-05-13 |



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| F 328 | Continued From page 13<br>day/night the saturations were checked were not documented. Those days the resident was checked showed s/he had saturations below the ordered parameters 4 times and was treated with oxygen on 1 occasion.<br>b. Review of the recorded vital signs and nurses' notes for August 2013 showed the resident's oxygen saturations were checked 3 times from 8/1/13 through 8/20/13 (20 days/40 ordered times). The times of day/night the oxygen saturations were checked was not documented. Of those days the saturations were checked, the resident showed s/he had saturations below the ordered parameters each time. Further, the documentation did not show the resident was treatment with oxygen.<br>c. Interview with the DON on 8/22/13 at 11:20 AM acknowledged the staff needed to follow the physician orders for oxygen therapy and document if interventions were taken. Further, the nursing staff needed to clarify the current order to determine if he wanted the resident's oxygen saturations to be checked through the night every 4 hours. | F 328 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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.<br><br>Based on a comprehensive assessment of a | F 329 | | |

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| F 329 | Continued From page 14<br>resident, the facility must 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary drugs for 2 of 9 sample residents (#8, #16). The findings were:<br><br>1. Review of the medical record showed resident #8 was admitted to the facility on 4/21/10 with diagnoses which included depression and dementia. Review of the physician orders showed the resident had a 2/23/11 order for the medication amitriptyline (antidepressant) 20 mg P.O. (by mouth) BID (twice a day). Review of the physician notes since the medication was ordered showed there was no attempt at a dose reduction, and no rationale for continuing amitriptyline at the same dosage. Review of the pharmacist monthly drug regimen reviews from 1/30/12 through 6/30/13 showed the resident's amitriptyline was not addressed.<br><br>2. Medical record review for resident #16 showed s/he had diagnoses to include dementia, anxiety | F 329 | **F329**<br>Residents #8 and #16 will have their Primary Physician review for possible drug dosage reductions and all rationale (for and/or against such reduction) will be noted.<br><br>MDS Coordinator will check for completeness of Dose Reduction reviews on a quarterly basis when the MDS is completed. Rationale on the Risk verses Benefit Statement will be reviewed at the weekly IDT meetings.<br><br>MDS Coordinator will report to QAPI on a quarterly basis for one year or until the committee recommends completion. | 10-05-13 |



9-16-13

9/24/13

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| F 329 | Continued From page 15<br>and depression. Review of the 7/17/13 physician orders showed the resident was prescribed Zoloft 50 mg (antidepressant) daily. The following concerns were identified:<br>a. Review of the physician order showed the medication Zoloft was prescribed initially on 8/19/11, 2 years ago. Review of the Risk verses Benefit Statement dated 9/1/12, 3/1/13 and 7/25/13 showed the physician had marked the following statement each time; "The benefit of this medication outweighs the risks associated with its use. Continue patient on this medication. Will re-evaluate medication use in 6 months or PRN." There was no rational for continued use of the medication or any recommendation to attempt a dose reduction. The physician did not indicate what the risks were associated with a gradual dose reduction.<br>b. Review of the monthly drug regimen review for 2012 through 2013 showed the pharmacist had not recommended a dose reduction for the antidepressant. Further, an interview with the pharmacist on 8/22/13 at 10:10 AM revealed she had not recommended a dose reduction for the resident.<br>c. Interview with the DON on 8/22/13 confirmed the physician had not requested a dose reduction and the risk versus benefit statement was the only documentation related to the medication Zoloft for reducing or discontinuing its use. | F 329 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit | F 425 | GMB 9-16-13 | |



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| F 425 | Continued From page 16<br>unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to remove medications that were expired in 1 of 1 medication storage areas. The findings were:<br><br>An observation on 8/22/13 at 9:15 AM with the ADON showed there were 3 single dose syringes of influenza vaccine in the medication refrigerator located in the medication storage room. The expiration date on each of the syringes was 6/30/13. An interview with the nurse at that time acknowledged the medications were expired and needed to be disposed of. | F 425 | **F425**<br>The three single dose syringes of influenza vaccine were removed from the medication refrigerator and destroyed per facility policy.<br><br>The ADON/DON will check all medications in the medication room and on the medication cart on a monthly basis to assure no medications are expired.<br><br>ADON/DON will report to QAPI on a quarterly basis for one year or until the committee recommends completion. | 10-05-13 |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed | F 428 | | |



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| F 428 | Continued From page 17<br>pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure the pharmacist identified and recommended the re-evaluation of long-term use of psychotropic drugs for 2 of 9 sample residents (#8, #16). The findings were:<br><br>1. Review of the medical record showed resident #8 was admitted to the facility on 4/21/10 with diagnoses which included depression and dementia. Review of the physician orders showed the resident had a 2/23/11 order for amitriptyline (anti-depressant) 20 mg P.O. (by mouth) BID (twice a day). Review of the monthly pharmacy drug regimen reviews from 1/30/12 through 6/30/13 showed the resident's amitriptyline was not addressed.<br><br>2. Medical record review for resident #16 showed s/he had diagnoses to include dementia, anxiety and depression. Review of the 7/17/13 physician orders showed the resident was prescribed Zoloft 50 mg (antidepressant) daily. The following concerns were identified:<br>a. Review of the physician order showed the medication Zoloft was prescribed initially on 8/19/11, 2 years ago. Review of the Risk verses | F 428 | **F428**<br>Residents #8 and #16 will have their Primary Physician and the Pharmacist review for possible drug dosage reductions and all rationale (for and/or against such reduction) will be noted.<br><br>ADON/DON will work with Pharmacist to assure the Monthly Drug Regimen Review is filled out completely with all recommendations noted. ADON/DON will work with Primary Physicians to assure all recommendations are addressed and any Actions/No Actions are noted.<br><br>MDS Coordinator will check for completeness of Dose Reduction reviews on a quarterly basis when the MDS is completed. Rationale on the Risk verses Benefit Statement will be reviewed at the weekly IDT meetings.<br><br>MDS Coordinator will report to QAPI on a quarterly basis for one year or until the committee recommends completion. | 10-05-13 |



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9/16/13

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| F 428 | Continued From page 18<br>Benefit Statement dated 9/1/12, 3/1/13 and 7/25/13 showed the physician had marked the following statement each time; "The benefit of this medication outweighs the risks associated with its use. Continue patient on this medication. Will re-evaluate medication use in 6 months or PRN." There was no rational for continued use of the medication or any recommendation to attempt to reduce the dose. The physician did not indicate what the risks were associated with a gradual dose reduction.<br>b. Review of the monthly drug regimen review for 2012 through 2013 showed the pharmacist had not recommended a dose reduction for the antidepressant Zoloft.<br><br>3. An interview with the pharmacist on 8/22/13 at 10:10 AM revealed she had not recommended a dose reduction for either resident. | F 428 | | |

9/16-13



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