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

PRINTED: 11/16/2013
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 _____	10/31/2013

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: CNA- Certified Nurse Aide DON- Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set mg- milligrams Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	The facility will ensure that the Attending or covering physician will be called immediately when a triggering event occurs, such as a fall with injury, mental health crisis, harm to others or life-threatening event. a. On 11/01/2013, a change in the Sublette Center policy manual, Nursing policy 1008-Incident Reporting, was made to read: 'The responsible party and the physician will be notified of every incident. Physician or covering physician will be contacted immediately by phone with all incidents such as fall with significant injury, mental health crisis, harm to self/others, or anytime the potential for physician intervention may occur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn C Walker RN — TITLE: Interim Administrator — (X6) DATE: 12/13/13

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.

12/27/13 PoC accepted with changes per conversation with Dawn Walker.
DoC = 12/17/13 Julia VanDyke, RN

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12/26/13 QV

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

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pg. 2 to be re-sent QV

12/27/13 - see end of document for pg. 2 QV

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician in a timely manner for 1 of 7 residents (#6) who had the need for physician notification concerning a change in condition. The findings were: Review of the medical record showed resident #6 was admitted to the facility on 6/14/13 with diagnoses which included depression and dementia. Review of nursing notes showed the resident attempted suicide on 9/10/13 at 1700 (5 PM). Review of a Residents' Problem List dated 9/11/13 at 7:42 AM (14 hours and 42 minutes after suicide attempt) showed the facility faxed information to the physician with the following, "Last evening, Resident was discovered by CNA. [S/he] was lying in [his/her] bed with a Gait belt wrapped around [his/her] neck and then around the Siderail on [his/her] bed. Stated "I just can't go on like this anymore." Numerous Verbal behaviors. "Give me a gun so I can shoot me." "Are those pills going to kill me." [Spouse] is very concerned about [his/her] behavior." The fax showed the physician responded on 9/11/13 at 10 AM (17 hours after suicide attempt). During an interview with the DON, interim administrator, and CNA supervisor on 10/30/13 at 3:15 PM, they	F 157	b. A change in the Sublette Center policy manual was made to Nursing policy 1000-Emergency Policy"' , "the licensed nurse will contact the resident's primary physician or covering physician to inform him/her of the situation immediately. c. The DON will audit each incident report within 1 business day to ensure the physician was notified. d. On 11/21/213 a nursing inservice was held advising of policy changes e. On 11/14/2013, the Prevention Coalition presented a mandatory inservice regarding Suicide Awareness and reporting f. QAPI meeting 12/17/2013 will address	

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12/12/13 SW

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F 157	Continued From page 2 confirmed the physician should have been notified immediately, and by phone or in person instead of by fax.	F 157		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change MDS assessment for 1 of 3 sample residents (#14) who required that type of assessment. The findings were: Review of the 6/2/13 quarterly MDS assessment revealed resident #14 required limited assistance for bed mobility, had no range of motion (ROM) limitations to the lower extremities, and had no pain in the past five days. A comparison to the 8/29/13 quarterly MDS assessment showed the resident declined in those three areas. The resident required extensive assistance with bed	F 274	The facility will identify and assess any resident within 14 days of a significant change in condition. a. A SCOS was initiated for resident #14 on 11/01/2013. IDT met and ensured the plan of care was up to date. b. The Sublette Center has coordinated an MDS team of 3 RN's to ensure collaboration regarding MDS issues. Formal training is planned for December 2013. c. Starting 11/07/2013, weekly interdisciplinary team meetings will now include discussion regarding, any residents with known changes. The team will identify and document potential SCOS's. d. Until training of MDS team has been completed, the administrator will conduct a twice monthly audit of all residents to identify potential SCOS, in conjunction with incident report review. e. Follow up will be initiated on 12/17/2013 as a function of QA	11/21/2013

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F 274	Continued From page 3 mobility, had ROM limitations to both lower extremities, and had indicators of pain daily in the past five days. During an interview on 10/31/13 at 9:50 AM the interim administrator agreed a significant change assessment should have been done. She stated with the turnover in MDS staff, it was a training issue.	F 274		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to revise the care plan as needed for 2 of 9 sample residents (#6, #14). The findings were:	F 280	• The facility will update resident's care plans within 72 hours of a change in care. The facility will ensure the above by: a. For resident #14, the MDS coordinator has changed the care plan to reflect the implementation of TABS alarm. b. In the future, any changes to the plan of care will be approved by the DON who will then ensure changes have been made to the current plan of care. c. the CNA manager, MDS coordinator, DON will meet on a weekly basis to coordinate shift report sheets, care issues, and care plans to avoid future errors. d. For resident #6, social services completed appropriate care plan 11/01/2013 to reflect the risk for self-harm. Initially, GDR done 08/30/2013 removing anti-psychotic from medication regimen. To address suicidal ideation, medication was reinstated on 09/11/2013, additionally, pain management was further looked at during 10/05/2013, by MD notes 10/10/2013, resident was noted as doing much better. e. Local counseling firm was notified and determined resident was not a good candidate for therapy due to advanced cognitive losses. However, MD was notified and is monitoring. f. follow up is occurring monthly at IDT meetings and QA, next 12/17/2013	12/17/2013

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F 280	Continued From page 4 1. Review of the 8/29/13 quarterly MDS assessment showed resident #14 experienced three falls, one with major injury, since the prior assessment. Observation of the resident during the survey on 10/28/13, 10/29/13 and 10/30/13 at various times revealed the resident utilized a Tabs personal motion alarm when in the wheelchair or recliner. However, review of the current care plan (printed 10/6/13) showed the Tabs alarm was not included as an intervention. During an interview on 10/29/13 at 5:50 PM the interim administrator and CNA supervisor stated the personal alarm was added after the resident's 8/18/13 fall from the recliner. They stated it was an oversight that it didn't get added to the care plan. 2. Medical record review showed resident #8 was admitted to the facility on 6/14/13 with diagnoses which included depression and dementia. Review of the care plan showed the facility implemented a care plan to address the resident's risk for suicide on 9/25/13. The following concerns were identified: a. The facility failed to initiate a care plan to address the resident's suicidal ideations until 9/25/13 (72 days after the first documented suicidal ideation). Review of the resident's nursing notes showed the following suicidal ideations: 7/15/13 at 2000 (8 PM)-"I might as well die." 7/16/13 at 10:15 AM-"Res has verbalized to members of staff that [s/he] wants a gun to kill [himself/herself], told housekeeper that [s/he] wanted to shoot self." 9/8/13 at 1015 (10:15 AM)-"Death is all I think about." b. The facility failed to initiate a care plan to address the resident's suicide attempt until 9/25/13 (15 days after suicide attempt). Review of	F 280	g. f. On 11/14/2013, the Prevention Coalition presented a mandatory inservice for all staff entitled, "QPR Gatekeeper Certification" seminar to promote suicide awareness/prevention. h. f. On 11/20/2013, the DON met with local High Country Behavioral Health to coordinate more mental health services at the Sublette Center. i. f. New social services employee will be responsible for ensuring appropriate social service/mental health care plans in the future. She will attend weekly IDT meetings and note residents at risk or actually experiencing issues in behaviors and/or mental health issues. j. f. Follow up will occur as a function of QA, next scheduled for 12/17/2013 12/17/2013	

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12/26/13 CV

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F 280	Continued From page 5 a 9/10/13 nursing note timed at 1700 (5 PM) stated the following, "CNA reported to this nurse that she found resident lying on [his/her] bed with a gait belt wrapped around [his/her] neck and then around the siderail." c. During an interview with the DON, Interim administrator, and CNA supervisor on 10/30/13 at 3:15 PM, they confirmed the facility failed to initiate a care plan to address the resident's suicidal ideations and suicide attempt in a timely manner. During an interview with the MDS coordinator on 10/30/13 at 4:40 PM, she confirmed the resident's care plan was not completed for suicide risk in a timely manner.	F 280		
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 the written plan of care was followed for 2 of 9 sample residents (#14, #25). The findings were: 1. Review of the current care plan for pain (printed 10/6/13) for resident #14 revealed staff were instructed to "evaluate effectiveness of analgesics." The following concerns were identified: a. Review of the September 2013 MAR revealed the resident was given Tylenol 650 mg PRN (as needed) for pain 24 times. However, the	F 282	The facility will provide quality services according to best care practices identified in the resident's care plan as evidenced by: a. For residents #14 and #25, the care plan states staff will, "evaluate effectiveness of analgesics". To insure this recommendation is followed, a number of intervention will be implemented: 1. on 11/21/2013, the DON held an inservice regarding medication follow up and follow through between nursing shifts. 2. the DON will monitor and audit PRN medication follow up in the MAR on at least 2 residents daily. This will be ongoing and reported on as a function of QAPI, next scheduled for 12/17/2013	12/17/2013

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12/30/13 CA

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F 282	Continued From page 6 effectiveness was not documented for 9 of the times (37.5%). Review of nursing notes for September 2013 revealed no documentation of effectiveness for those 9 times. b. Review of the October 2013 MAR through 10/28/13 showed the resident was given PRN medication (Tylenol 650 mg, Celebrex 200 mg, or Aleve 220 mg) for pain 34 times. The effectiveness was not documented for 14 of 34 times (41%). Review of nursing notes showed the effectiveness was only documented once out of the 14 times. 2. Review of the current care plan (printed 10/17/13) for resident #25 for pain revealed staff were instructed to "monitor for effectiveness of medications." The following concerns were identified: a. Review of the September 2013 MAR and nursing notes revealed the resident was given PRN pain medication (Tylenol 650 mg or Lortab 5/500 mg 1/2 tab) 15 times. Of the 15 times, the effectiveness was not documented 4 times (26.6%). b. Review of the October 2013 MAR through 10/28/13 showed the resident received PRN pain medication (Tylenol 650 mg or Lortab 5/500 mg) 21 times. However, the effectiveness was not documented 9 of the 21 times (42.8%). Review of nursing notes failed to show documentation of the effectiveness. 3. During an interview on 10/30/13 at 4 PM the DON stated the effectiveness of the PRN pain medications should be documented in the MAR. She stated she had been doing audits to monitor that and had identified issues with the lack of documentation.	F 282	b. c. d. e. f. The staff development coordinator will monitor this plan of correction with additional audits on PRN medication follow up in the MAR, which began 11/01/2013. This audit will occur for each resident every month, reporting outcomes to the DON. In turn, the DON will report on outcomes as a function of QAPI, next scheduled for 12/17/2013 c d. The pharmacy consultant will observe and audit 2 med passes per month and will note follow up on PRN medications. d. e. The staff development coordinator will audit medication passes on a regular basis, which will be reported on as a function of QAPI. e. f. The DON and administrator are currently researching EMR to assist in prompting medication follow up 12/17/2013	

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F 309 F 309 SS=E	Continued From page 7 483.25 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 observation, medical record review, staff and family interviews, and policy review, the facility failed to ensure care was provided to ensure safety for 1 of 1 sample resident (#6) with suicidal ideations. In addition, the facility failed to monitor the effectiveness of pain medication to ensure pain relief for 3 of 5 sample residents (#14, #15, #25) who received PRN (as needed) pain medications. The findings were: Findings related to care of a resident with suicidal ideations: 1. Review of the medical record for resident #6 showed s/he was admitted to the facility on 6/14/13 with diagnoses which included depression and dementia. Review of a 7/16/13 Phone Note showed the resident's physician received a call from facility staff as follows: "Call for: Severe depression with suicidal thoughts. Summary of Call: Received a call from the nursing home facility that [resident's name] was having suicidal thoughts and statements secondary to[his/her] severe depression [s/he] is	F 309 F 309	The facility will strive to maintain the highest level of care possible. We will accomplish this mission by implementing the following: a. For resident #6, nursing policies 1000 and 1008 were changed as well as a change in the resident's care plan, reflecting risk for suicidal ideation, effective 11/01/2013 b. As noted during survey, nursing (for resident #6) escorted resident to his room and placed on "suicide rounds at least every 2 hours", the failure of documentation regarding changes to the environment as well as the need for q15 minute checks were reviewed both with individual nurses and nursing staff as a whole during a mandatory nursing meeting 11/21/2013. c. For resident #6 (and future at risk residents) the Prevention Coalition conducted QPR Gatekeeper Certification seminar, which was a mandatory training for all staff. The seminar was held on 11/14/2013. d. On 11/20/2013, the DON met with High Country Behavioral Health to ensure increased psychosocial services at the Sublette Center. e. During the 11/21/2013 mandatory nurses' meeting, the topic of physician calls was discussed.	

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12/24/13 DV

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F 309	Continued From page 8 already on a SSRI. [S/he] has had episodes like this in the past I did discuss it with [spouse] and we have decided to put [him/her] on Zyprexa 2.5 mg by mouth twice a day we will follow [him/her] closely and follow up with [him/her] in person in 1-2 weeks." Review of a 9/10/13 nursing note timed at 1700 (5 PM) stated the following, "CNA reported to this nurse that she found resident lying on [his/her] bed with a gait belt wrapped around [his/her] neck and then around the siderail." Review of a 9/10/13 nursing note timed 1730 (5:30 PM) showed, "Will these pills kill me." Will check resident often and monitor. Behavior reported to nurse coming on duty." The following concerns were noted: a. Review of the medical record showed no evidence the facility ensured the resident's room and environment was safe in order to prevent another attempt after the resident's 9/10/13 suicide attempt. Observation on 10/30/13 at 11:30 AM showed the resident in a recliner chair alone in his/her room. Further observation showed a call light cord long enough to reach from the wall to the resident's bedrail, and was wrapped around the bedrail several times. The observation showed the resident was receiving oxygen via oxygen tubing that extended from the wall to the resident with ample length for the resident to move around in his/her chair. The observation showed corrugated tubing connected to the resident's respiratory updraft machine that was long enough to reach the resident with extra length for adjusting in the chair. b. The facility failed to notify the physician on 9/10/13 concerning the resident's suicide attempt. Review of a Residents' Problem List dated 9/11/13 at 7:42 AM (14 hours and 42 minutes after suicide attempt) showed the facility faxed information to the physician with the following,	F 309	1. a. On 11/01/2013, a change in the Sublette Center policy manual, Nursing policy 1008-Incident Reporting, was made to read: "The responsible party and the physician will be notified of every incident. 2. b. On 11/01/2013 A change in the Sublette Center policy manual was made to Nursing policy 1000-Emergency Policy"', "the licensed nurse will contact the resident's primary physician or covering physician to inform him/her of the situation immediately." 3. c. A directive to follow amended policies was given by the DON at the mandatory nursing in-service 11/21/2013, to which nurses verbalized understanding and agreement. f. The DON introduced "safety checks" worksheet what will now be used for any resident at risk for self harm, falls, aggressive behaviors and significant changes in mental status, effective 11/21/2013 g. the DON will audit these safety/visual checks on the next business day following an incident and every business day while checks are in place to prevent this lack of documentation in the future. Follow up will be reported as a function of QAPI, next scheduled for 12/17/2013 h.. The DON will audit all Incident reports to insure that the physician or on-call counterpart was notified immediately upon significant event. Follow up will be reported as a function of QAPI, next scheduled for 12/17/2013	11/21/2013

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	535017	A. BUILDING _____ B. WING _____	10/31/2013

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

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F 309	Continued From page 9 "Last evening, Resident was discovered by CNA. [S/he] was lying in [his/her] bed with a Gait belt wrapped around [his/her] neck and then around the Siderail on [his/her] bed. Stated "I just can't go on like this anymore." Numerous Verbal behaviors. "Give me a gun so I can shoot me." "Are those pills going to kill me." [Spouse] is very concerned about [his/her] behavior." The fax showed the physician responded on 9/11/13 at 10 AM (17 hours after suicide attempt). c. The facility failed to document specific interventions implemented on 9/10/13 after the resident's 1700 (5 PM) suicide attempt. Review of the 9/10/13 nursing note at 1730 (5:30 PM) stated, "Will check often and monitor." However, the note failed to specify frequency of monitoring. Review of the Resident Monitoring dated 9/11/13 showed monitoring documentation started at 1800 (6 PM) (25 hours after suicide attempt). The document was designed for every 15 minute monitoring. However, the Q 15 minute (every 15 minute) part was marked out and replaced with hourly monitoring. Review of the entire medical record and incident information showed no additional monitoring concerning the 9/10/13 suicide attempt was documented. d. The facility failed to ensure adequate social services interventions were in place for the resident after the resident's 9/10/13 suicide attempt. Review of the social services notes showed on 9/23/13 (13 days after suicide attempt) the social services director (SSD) contacted a local counselor concerning the resident. The review showed no further documentation concerning counseling for the resident. Interview with the SSD on 10/30/13 at 4:15 PM revealed the SSD and counselor had an undocumented conversation over the phone, and the counselor felt the resident would not benefit	F 309	h. The DON gave an additional directive at the 11/21/2013 meeting that nurses will call the DON on cell, if out of the building, whenever there is a suicidal ideation or life threatening event to ensure proper adherence to policies. i. The facility administrator, in conjunction with the DON will be performing ongoing audits to ensure compliance. The results of these audits will be reported on as a function of QAPI. For resident #14, there was a lack of documentation regarding the follow-up of PRN pain medications. The facility will ensure timely follow up on PRN medications, including pain medications with the following interventions: a. Follow up on PRN medication was addressed at the 11/21/2013 nurses in-service. The directive was given to the Nurses that all PRN medications will be followed up for effectiveness and documented in the MAR each and every dose.	11/21/2013

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F 309	Continued From page 10 from counseling due to his/her level of dementia. The SSD confirmed the counselor did not see the resident, and the facility failed to pursue an assessment for counseling assistance for the resident any further. e. The facility failed to care plan the resident's suicide ideations and suicide attempt in a timely manner. Review of the care plan showed the facility implemented a care plan to address the resident's risk for suicide on 9/25/13 (15 days after suicide attempt). Review of the resident's nursing notes showed the following suicidal ideations prior to the 9/10/13 suicide attempt: 7/15/13 at 2000 (8 PM)-"I might as well die." 7/16/13 at 10:15 AM-"Res has verbalized to members of staff that [s/he] wants a gun to kill [himself/herself], told housekeeper that [s/he] wanted to shoot self." 9/8/13 at 1015 (10:15 AM)-"Death is all I think about." Review of the Psychoactive Medication Monthly Record for September and October 2013 showed on the day shift of 9/10/13 (prior to the 9/10/13 suicide attempt) the resident "Speaks of Death" 10 times, "Wants someone to kill [him/her]" 10 times, "Desire to die" 10 times. Review showed the resident last had suicide ideations on 10/20/13. f. During an interview with the DON, interim administrator, and CNA supervisor on 10/30/13 at 3:15 PM, they confirmed the facility failed to document interventions taken to monitor the resident after the 9/10/13 suicide attempt until 9/11/13 at 1800 (6 PM). The administrator stated the resident should have been monitored at least every 15 minutes with appropriate documentation, and the resident's room should have been monitored and documented to ensure a safe environment. They further confirmed the physician should have been notified immediately, and by phone or in person instead of by fax. They	F 309	b. The staff development coordinator will monitor this plan of correction with audits on PRN medication follow up in the MAR on each resident's MAR every month and report to the DON to insure compliance. c. The pharmacy consultant will observe and audit two medication passes per month and will note follow up on PRN medications d. The staff development coordinator and DON will audit medication passes on a regular basis and will audit medication follow up. e. Reporting of results will be reported on as a function of QAPI, next scheduled for 12/17/2013 12/17/2013 For resident #15, to follow up on pain medications that were given. The plan of action is as follows: a. At the 11/21/2013 in-service, the DON advised to all nurses that PRN medications will be followed up on for effectiveness and documented in the MAR each and every dose	

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12/30/13

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F 309	Continued From page 11 stated the resident had improved since the physician switched the resident's anti-depressant on 10/24/13 to Lexapro 10 milligrams by mouth each night. During an interview with the resident's spouse on 10/30/13 at 2:15 PM, s/he felt the resident has improved since being switched to Lexapro. g. During an interview with the DON, Interim administrator, and CNA supervisor on 10/30/13 at 3:15 PM, they confirmed the facility staff failed to bring this issue to administrative staff attention until 9/17/13 (one week after suicide attempt). According to the facility policy and procedure titled, "INCIDENT REPORTING" revised 8/27/13, the following is stated, "POLICY: All reportable incidents shall be documented and verbally reported immediately and reviewed by the Director of Nursing within 24 hours. PROCEDURE: Definitions: A Reportable Incident is any occurrence which is not consistent with the routine operation of the Sublette Center or the routine care of a particular patient.....They may include the following:.....Behavioral occurrences.....Any incident which may result in patient or staff injury." Findings related to pain: 1. Review of the 8/29/13 quarterly MDS assessment showed resident #14 had indicators of pain daily in the previous 5 days. In addition, review of a pain assessment dated 10/8/13 showed the resident currently had pain, and was scored an "8" for "moderate" pain on the Abbey pain scale (used in residents with dementia who cannot verbalize). Review of the current care plan for pain (printed 10/8/13) revealed staff were instructed to "evaluate effectiveness of analgesics." The following concerns were	F 309	b. The staff development coordinator will monitor this plan of correction with audits on PRN medication follow up in the MAR on each resident's MAR every month and report to the DON to insure compliance. c. The pharmacy consultant will observe and audit two medication passes per month and will note follow up on PRN medications d. The staff development coordinator and DON will audit medication passes on a regular basis and will audit medication follow up. e. The DON will monitor and audit PRN medication follow up in the MAR for at least 2 residents on a daily basis for the next quarter or until significant improvement has been noticed, at which time, the monitoring will reduce. f. Monitoring and results will be reported as a function of QAPI, next scheduled for 12/17/2013	12/17/2013

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12/20/13 EV

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F 309	Continued From page 12 identified: a. Review of the September 2013 MAR revealed the resident was given Tylenol 650 mg PRN for pain 24 times. However, the effectiveness was not documented for 9 of the times (37.5%). Review of nursing notes for September 2013 revealed no documentation of effectiveness for those 9 times. b. Review of the October 2013 MAR through 10/28/13 showed the resident was given PRN medication (Tylenol 650 mg, Celebrex 200 mg, or Aleve 220 mg) for pain 34 times. The effectiveness was not documented for 14 of 34 times (41%). Review of nursing notes showed the effectiveness was only documented once out of the 14 times. 2. Review of the 9/30/13 significant change MDS assessment showed resident #26 had pain almost constantly that was an "8" on a scale of 1 to 10. In addition, review of the 10/6/13 care area assessment (CAA) for pain revealed the resident had experienced a greater trochanter fracture and nursing staff provided pain control. Review of the current care plan (printed 10/17/13) for pain showed staff were instructed to "monitor for effectiveness of medications." The following concerns were identified: a. Review of the September 2013 MAR and nursing notes revealed the resident was given PRN pain medication (Tylenol 650 mg or Lortab 5/500 mg 1/2 tab) 15 times. Of the 15 times, the effectiveness was not documented 4 times (26.6%). b. Review of the October 2013 MAR through 10/28/13 showed the resident received PRN pain medication (Tylenol 650 mg or Lortab 5/500 mg) 21 times. However, the effectiveness was not documented 9 of the 21 times (42.8%). Review of	F 309	For resident #25, to follow up on pain medications that were given. The plan of correction includes a directive given to nurses at the 11/21/2013 mandatory meeting that all PRN medications are to be followed for effectiveness and documented in the MAR each and every dose. a. The DON will monitor and audit PRN medications for follow up in the MAR on at least two residents daily for the next quarter or until significant improvement in documentation is noticed at which time, monitoring will decrease. b. The staff development coordinator will audit medication passes on a regular basis as well as auditing medication follow up each month with a MAR audit. c. The pharmacy consultant will monitor two medication passes per month as well as review and note PRN medication follow up. d. Follow up will occur as a function of QA, next scheduled for 12/17/2013 For resident #14, a change was made in the care plan 11/23/2013 to include the following statement, "Pain will be	12/17/2013

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F 309	Continued From page 13 nursing notes failed to show documentation of the effectiveness. 3. Review of the 9/26/13 admission MDS assessment for resident #15 showed s/he had pain present during the previous 5 days almost constantly. The review showed the resident had indicated his/her highest level of pain in the last 5 days was rated at 10, the highest pain level. Review of the care plan for "At risk for pain not well controlled" reviewed last on 9/25/13, showed as a goal "Pain will be controlled within acceptable limits for resident." The following concerns were identified: a. The care plan failed to identify what the acceptable limits were for controlling the resident's pain. b. Review of the September and October 2013 MARs from admission on 9/13/13 through 10/28/13 showed the resident was given PRN pain medication (Norco 10/325 mg) for pain 78 times. Review of the follow-up medication administration documentation showed the facility failed to document the effectiveness of the Norco 41 times (53%). Review of the nursing notes from admission through 10/28/13 showed the effectiveness was not documented. 4. During an interview on 10/30/13 at 4 PM the DON stated the effectiveness of the PRN pain medications should be documented in the MAR. She stated she had been doing audits to monitor that and had identified issues with the lack of documentation. 5. Review of the facility's policy "Pain Assessment Policy" (last reviewed 8/13) showed "...If a resident is given a PRN pain medication the nurse is to document time the PRN medication	F 309	...controlled within acceptable limits for resident, not to exceed 4 hours initially, then assessments for pain will continue every shift when he/she is stabilized." Review and monitoring will be reported on as a function of both IDT and QAPI.	12/17/13

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F 309	Continued From page 14 was given, type of pain, place of pain, how bad the pain is and if any non-pharmacological interventions were implemented prior to administering the PRN pain medication. The nurse is to re-assess the resident 30 minutes after giving the pain medication to assess if the medication was adequate."	F 309		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer staff interview, and review of manufacturer's instructions and Centers for Disease Control guidelines, the facility failed to ensure the air in 2 of 3 resident hallways (North, East) was not contaminated with airway and eye irritants. The findings were: During an observation on 10/28/13 at 5 PM outside of room #11 (North Hallway), there was a distinct odor of ozone in the air. The observation showed there were 2 QT Tornado units (ozone producing device) mounted at 8 feet high in the North hallway, and the unit outside of room #11 was in use. Further observation showed there was one ozone unit each mounted at 8 feet high on the East and West hallways that were not in use at that time. The following concerns were noted: a. Review of the manufacturer's instructions	F 465	The facility will ensure that the environment is safe, functional, sanitary and comfortable for residents, staff and public. The facility will ensure compliance by: a. on 11/15/2013, maintenance supervisor removed QT Tornado (4) from operation. These units were replaced with ORECK Air Purifiers. The new units are electronic filtration systems and catalytic odor and ozone removal systems. "These technologies can provide Broad protection against airborne particles, bacteria, mold, viruses, fungi, chemical fumes and odors that are reduced through the air purifier for a healthier, cleaner environment" b. Monitoring will occur as a function of QA	11/15/2013

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12/26/13 DV

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F 465	Continued From page 15 for use of the QT Tornado stated, "The housekeeper should always clean the guestroom before using the QT Thunder unit and vacate the room while the unit is in operation....Once the timer is set, turn on the unit and leave the room." b. During a phone interview with a QT Tornado representative on 10/29/13 at 8:45 AM, he stated the facility should follow the manufacturer's instructions and set the timer, then leave the room while the unit is in use. He further stated that people should not be in the area when the unit is in use. c. According to the Centers for Disease Control website at www.cdc.gov, accessed on 11/6/13, the Occupational Health Guideline for Ozone included under "HEALTH HAZARD INFORMATION" that Routes of Exposure: "Ozone affects the body by being inhaled or by irritating the eyes, nose, and throat." The effects of exposure included: "When a person is exposed to very low concentrations of ozone for even a brief period of time, the person may notice a sharp, irritating odor. As the concentration of ozone increases, the ability to smell it may decrease. Irritation of the eyes, dryness of the nose and throat, and cough may be experienced. If the ozone concentration continues to rise, more severe symptoms may develop. These may include headache, upset stomach, or vomiting, pain or tightness in the chest, shortness of breath or tiredness, which may last for several days to weeks. Finally, with higher levels of exposure, the lungs may be damaged and death may occur." d. The observation on 10/28/13 at 5 PM revealed the ozone filled air was irritating to the surveyor's eyes. e. During the 10/28/13 observation at 5 PM, the ozone unit outside of room #11 was operating and set on a 9 (out of 10) level, with the timer set	F 465		

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F 466	Continued From page 16 at 6. The additional ozone unit was not turned on. During the survey, the unit outside of room #11 was on at all times with no changes in settings on 10/28/13, 10/29/13 and 10/30/13 until 10:05 AM. Observation on 10/29/13 at 8:50 AM showed the unit outside of room #205 (East Hallway) was operating for 30 minutes. f. During an interview with CNA #1 on 10/30/13 at 9:35 AM, she stated staff turn on and use the ozone units as needed to "freshen" the air, with no specific timeframes or settings when used. During an interview with CNA #2, she stated facility staff "freshen" the air in each of the 3 resident hallways using the ozone units as needed. g. During an interview on 10/30/13 at 10:05 AM with the housekeeping supervisor, he stated he was unaware the ozone units were not to be used with people around. He promptly removed the units from the facility at that time. He stated the units were used for months to years, and could not remember the exact time the units were first used. He further stated the CNAs and nursing staff turned on the units as needed to "freshen" the air.	F 466		