Approved 9/8/14 as previously accepted on 8/12/14. Linda Brown RN

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing IDT: Intendisciplinary Team LPN: Licensed Practical Nurse MDS: Minimum Data Set BIMS: Brief interview for mental status RN: Registered Nurse MAR: Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure dignity was maintained for 2 of 14 sample residents (#22, #80) and 3 non-sample residents (#24, #26, #39). The findings were: 1. Observation on 7/8/14 at 8:57 AM showed resident #22 was in the dining room wearing plaid pajama bottoms and a sweat shirt. Later that same day at 10:35 AM the resident was sitting in the lounge dressed in the same clothing. Review	F 241	F 241 The facility strives to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	8/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: R. Brown Allen — TITLE: Administrator — (X6) DATE: 9/2/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 of the 5/19/14 annual MDS assessment showed the resident was severely cognitively impaired and required extensive assistance with dressing. An interview with the unit manager on 7/9/14 at 5:15 PM acknowledged the resident was very attentive regarding his/her appearance and would not have selected to wear what was observed. 2. Observation on 7/7/14 at 5:10 PM showed residents #24, #26, #39, were brought into the dining room. The residents' hair was uncombed and flat against their heads on the side it appeared they had laid on. An interview with unit manager #1 on 7/9/14 at 5:15 PM indicated the residents hair needed to be combed before leaving their rooms for meals. 3. Observation on 7/8/14 at 9 AM showed resident #80 was propelling him/herself in a wheelchair. The wheelchair was noted to have a seatbelt which was buckled over the resident's legs. The buckle and straps of the seatbelt were soiled with spilled food. Observation of the resident on 7/9/14 at 1:12 PM showed the resident's wheelchair seatbelt remained in the same soiled condition. Interview with LPN #1 and CNA #1 at that time confirmed the resident's lap belt was soiled with probable food remnants. The LPN then showed the surveyor a posted cleaning schedule which included the resident's wheelchair to be cleaned once a week. However, the LPN acknowledged staff were required to clean wheelchairs and lap belts any time they get dirty, and confirmed staff had failed to clean the lap belt in a timely manner for this resident.	F 241	Corrective Action: Resident # 22 are dressed in clothing that reflects her preferences of appearance. Resident 22's clothing was changed when identified during the survey. Resident # 24, #26, # 39 attend meals with hair that is combed according to their individuality. Resident #24, #26, #39 hair was combed when identified during the survey. Resident #80 seat belt was cleaned on 7/9/14. Identification of Others: The Nurse Managers/Designee and DON/Designee will observe grooming, clothing attire and cleanliness of seat belts during 4 meals to ensure residents hair is combed and that clothing attire reflects individuality and seat belts are free of spilled food. Any concerns will be written on a QAPI auditing tool and 1:1 education will be provided by the Nurse Managers/Designee and DON/Designee. Systemic Changes: In service education will be provided to the nursing staff by the SDC/designee on Dignity and Respect of Individuality on or F241 Systemic Changes (continued) before the date of compliance. The DON/ degignee will complete 10 weekly random observations of resident attire and hair as well as seat belts and review finding with IDT at morning business meeting Monday through Friday.	

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F 241	Continued From page 2	F 241	Monitor: The Quality Assurance and Performance Improvement Committee meets monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months the re-assess the need for continued monitoring based on compliance.	
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:	F 274		8/20/14

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F 274	Continued From page 3 Based on medical record review and staff interview, the facility failed to ensure a significant change assessment was completed for 1 of 1 sample resident (#22) with a significant change. The findings were: Review of the 4/2/14 nurse's note timed at 12:30 AM for resident #22, showed the nurse had heard a loud noise and the resident "yelling for help" from his/her room. The resident was found on the floor with skin tears and bruising. Further, the resident complained of lower back pain. The radiology report dated 4/10/14 showed an acute fracture of the thoracic spine. Review of the 3/3/14 quarterly MDS assessment showed the resident required only supervision in the following areas: bed mobility, transfer, walking in the room, toilet use and personal hygiene. Further, it showed the resident had not fallen since prior to the most recent assessment. Review of the 5/19/14 annual MDS assessment, completed after the fall, showed for bed mobility it had only occurred 1-2 times in a 7 day period. In addition, for transfers, walking in the room, toilet use and personal hygiene, the resident required extensive assist. During an interview with the MDS coordinator on 7/9/14 at 3:25 PM, she acknowledged a significant change assessment should have been completed following the fall and decline in activities of daily living.	F 274	F 74 The facility will conduct a comprehensive assessment of 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. Corrective Action: Resident # 22 had a significant change of condition assessment completed on date Identification of Others: MDS Coordinator/Designee to review nurses notes for the past 30 days to determine if a significant change of status assessment is needed. Those identified will be scheduled with ARD's and completed within 14 days of the identification. Systemic Changes: Resident's will be reviewed for significant changes during the morning business meeting Monday thru Friday by discussion, telephone orders, 24 hour report and incident reports for changes of condition. The IDT will determine if a significant change of condition is needed. The ARD will be set within 14 days if the IDT determines a significant change assessment is warranted. The residents with significant change of condition will be monitored and tracked on the Electronic Care Management Board. The IDT will be	

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F 274	Continued From page 4	F 274	educated by the Divisional Director of Care Management or Designee on the completion and identification of a significant change of status assessment within 14 days of the identification of the significant change with reference to the RAI Manual. The NHA/Designee will review the assessment schedule weekly to determine the completion timeliness of any identified significant change of condition assessment. Monitor: The Quality Assurance and Performance Improvement Committee meets bi-monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported bi-monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need to continued monitoring based on compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		8/20/14

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F 279	Continued From page 5 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 17 sample residents (#40). The findings were: Medical record review showed resident #40 was admitted to the facility on 1/23/14 with diagnoses which included seizure disorder. Review of a 6/5/14 social services note revealed, "Family doubts they will be able to care for [the resident] at home due to [the residents] hitchhiking behaviors..." Interview with the social services director on 7/9/14 at 5 PM revealed she was aware the resident had past drug and alcohol seeking behaviors; however, she felt that because this was not the same city/town the resident previously resided in, the resident would not seek to elope in search of these items. Review of the medical record showed no documentation concerning past alcohol or mood	F 279	F 279 Corrective Action: Resident #40 comprehensive plan of care has been updated to include resident's level of wandering and elopement risk. Identification of Others: An audit has been conducted of residents with wandering risks and high risk for elopement per the elopement assessment for appropriate care plan. Systemic Changes: The Interdisciplinary Team will be in serviced by the DON/Designee concerning updating care plans with resident changes and risk. The MDS	

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F 279	Continued From page 6 altering drug abuse. Review of the 7/4/14 IDT post fall review showed, "South Nurse brought resident back to unit (Rock Creek) at about this time stating resident was found on the ground in the East parking lot by people walking on side walk. It is unknown exactly where [the resident] was found in the parking lot or what position [the resident] was in." Further review showed conditions that may have contributed to the fall were, "previous elopement outside." The following concerns were identified: a. Review of the care plan confirmed the facility failed to initiate a plan of care for wandering and elopement until 7/4/14, the day of the resident's unwitnessed fall outside of the facility. At that time, a wanderguard device was added to alert staff if the resident should leave the building. b. Interview with the DON on 7/10/14 at 8 AM verified that prior to the 7/4/14 fall, the resident was known by staff to frequently leave the building and walk outside without staff present. She further confirmed although staff were aware of this, there was no documentation in the medical record to show the activity was safe for the resident. Further, she verified prior to having the wanderguard device, the resident could leave the building without staff being aware.	F 279	Coordinator/Designee will complete a random weekly audit of care plans to ensure care plans are present to reflect current resident needs and risks. Monitor: The Quality Assurance and Performance Improvement Committee meets bi-monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for pattern and trends reported bi-monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	
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	F 280		8/20/14

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F 280	Continued From page 7 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 review and revise the care plan for 3 of 17 sample residents (#22, #36, #37). The findings were: 1. Review of the 5/13/14 admission MDS assessment showed resident #37 was severely cognitively impaired with a BIMS score of 3. Further, the resident had behaviors to include wandering which occurred daily and used a walker for ambulation. S/he was unsteady but able to stabilize him/herself. Review of the falls documentation showed the resident had fallen 6 times from May through July 2014, and 5 of the 6 falls indicated they were unwitnessed. The nursing admission intake dated 5/2/14 showed the resident had a walker but would forget to use it. Observation on 7/8/14 at 9:55 AM showed the resident was in the hallway without a walker. The CNA indicated the resident was to use a walker or wheelchair for locomotion. In addition, the resident had been sitting in a recliner and the	F 280	F 280 The resident has the right unless judged incompetent or otherwise found to be incapacitated under the laws of the state, to participate in care planning 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	

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F 280	Continued From page 8 motion sensor was located on the wheelchair and not attached to the resident. Interview with CNA #3 on 7/9/14 at 12:40 PM revealed the alarm was to be attached to the resident while in the recliner. Further, he revealed the resident would remove the alarm and dismantle it. Review of the care plan for falls last reviewed on 7/7/14 showed interventions included an alarm while the resident was sitting in the recliner, and for staff to determine potential patterns related to the resident's falls. The approaches failed to include details related to the potential patterns and that the resident would at times remove the alarm. The staff was also to place frequently used items within reach of the resident; however, the plan did not indicate what those items were. 2. Review of the 5/19/14 annual MDS assessment showed resident #22 was severely cognitively impaired with a BIMS score of 3. Further, s/he had wandering behaviors that occurred daily and had a history of falls with injuries. The resident used a walker with ambulation. Review of the IDT post fall review showed the resident fell 8 times between 4/2/14 and 6/25/14. Seven of the eight falls were unwitnessed with 6 resulting in injuries to include skin tears, bruising, minor head injuries, and a fracture of the lumbar region of the back on 4/2/14. Review of the care plan for falls last reviewed on 7/3/14 showed the resident was to be observed for potential patterns of falls to identify possible causes, none were identified. Further review showed interventions included keeping frequently used items within reach. It did not include what items were to be within reach for this resident. 3. Review of the 5/7/14 quarterly MDS	F 280	resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Corrective Action: Resident #22 and #37 comprehensive plan of care for falls has been reviewed and updated to include interventions and approaches that are detailed and individualized Resident #36 comprehensive plan of care for behaviors has been reviewed and updated to include specific triggers and indicators along with interventions and approaches that are detailed and individualized. Identification of Others: A record review of resident's receiving a quarterly, annual or significant change of condition assessment in the last 30 days was conducted to determine the need for care plan revision and development of individualized triggers, indicators and interventions and approaches that are detailed. All resident's receiving an assessment within this period will have care plans reviewed by the IDT for revision. Systemic Changes: The interdisciplinary Team will be in serviced by the DON/Designee concerning reviewing, updating and developing individualized and detailed care plans as needed and upon admission, change of condition and annually.	

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F 280	Continued From page 9 assessment for resident #36 showed his/her cognitive skills for daily living were severely impaired. Further, the resident had demonstrated physical behaviors directed toward others, wandering, and rejection of care. Review of the behavior flow sheet for medication administration and non-pharmacological showed the resident was monitored for the following behaviors; hitting, kicking and spitting, crying and paranoia. Review of the care plan for behaviors last reviewed on 5/8/14 showed the staff were to check for discomfort. It did not include what the resident's indicators were for pain. The staff was to be alert for "triggers of undesired behavior." It did not include what those triggers were. Further, the environment, situation or treatment was to be modified to minimize episodes of undesirable behaviors. The care plan did not show how and what situations/ environmental conditions might need to be modified. During an interview with the unit manager #1 on 7/8/14 at 5:15 PM, she acknowledged interventions for falls and behaviors needed to be better developed.	F 280	The Interdisciplinary Team will review telephone orders, the 24 hour report, incident and accidents each business day during the morning business meeting and revise and develop care plans as needed. The Interdisciplinary Team will review care plans during Care Management Risk Review Meetings for detailed and individualized indicators, triggers, approaches and interventions. The MDS Coordinator/Designee will verify that care plans are developed using detailed and individualized triggers, indicators, approaches and interventions. During care conference quarterly, annually, and with change of condition. Monitor: The Quality Assurance and Performance Improvement Committee meets bi-monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported bi-monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		8/20/14

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F 312	Continued From page 10 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure residents were provided services related to grooming and personal care for 6 non-sample residents (#23, #24, #26, #29, #39) who required assistance and lived on the secured unit. The findings were: 1. Observation on 7/8/14 at 11:25 AM showed resident #29 had a stain down the front of his/her shirt that appeared to be spilled liquid. The stain had been noted earlier that day during breakfast. Review of the 6/3/14 quarterly MDS assessment showed the resident was severely cognitively impaired with a BIMS score of 3. Further, the resident required extensive assistance with dressing and personal hygiene. 2. Observation on 7/7/14 at 3:15 PM showed during the initial tour resident #23 wore a white sweater with brown stains down its front. The stains appeared to be coffee. At 4:55 PM that same day the resident was sitting in the dining room wearing the same stained white sweater. In addition, the resident's hair had not been combed and was flat against the back of his/her head. Review of the 6/11/14 quarterly MDS assessment showed the resident was severely cognitively impaired with a BIMS score of 4. Further, the resident required supervision with dressing. 3. Observation on 7/7/14 at 5:10 PM showed	F 312	F 312 ADL Care provided for Dependent Residents The facility strives to ensure that 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. Corrective Action: Resident #29 was assisted to change into Resident #23 was assisted into a stain free sweater and hair was combed on 7/7/14 and ongoing. Resident #26 was assisted with hair grooming on 7/7/14 and ongoing. Resident #24 was assisted with hair grooming on 7/7/14 and ongoing. Resident #39 was assisted with hair grooming on 7/7/14 and ongoing. Identifications of Others: Systemic changes: DON/Designee will complete weekly random observations of grooming and resident's clothing and review with IDT at	

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F 312	Continued From page 11 resident #26 was in the dining room. The resident's hair was ungroomed and flat against the back of his/her head. Review of the 5/16/14 quarterly MDS assessment indicated the resident was severely cognitively impaired and needed supervision with dressing and personal hygiene. 4. Observation on 7/7/14 at 5:10 PM revealed resident #24 was in the dining room. His/her hair was messed and appeared it had not been combed. Review of the 5/16/14 annual MDS assessment showed the resident was moderately cognitively impaired. Further, the resident required supervision with dressing and personal hygiene. 5. Observation on 7/7/14 at 5:10 PM showed resident #39 was in the dining room. The resident's hair was flat against the back of his/her head appearing the resident had recently been lying in bed. Review of the 6/19/14 admission MDS assessment showed the resident was moderately cognitively impaired and needed assistance with dressing and personal hygiene. 6. An interview with unit manager #1 on 7/9/14 at 5:15 PM indicated the residents hair needed to be combed before leaving their rooms for meals. Further, clothes stained with food and drinks needed to be changed.	F 312	morning meeting Monday through Friday. SDC/designee will provide education on or before the date of compliance for all licensed staff on grooming and changing stained clothing. Monitor: The Quality Assurance and Performance Improvement Committee meets monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	
F 323 SS=E	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.	F 323		8/20/14

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, medical record review, and fall document review, the facility failed to ensure effective supervision and interventions were in place to prevent falls for 3 of 5 sample residents (#20, #22, #37) with falls. The findings were: 1. Review of the falls care plan dated 3/4/14 showed resident #20 was at a risk of falls related to mental status, psychotropic drug use, use of blood pressure medication, recent urinary tract infections (UTI), and pain. Review of the 2/28/14 annual MDS assessment and the 5/19/14 quarterly MDS assessment, the resident required supervision and one person physical assistance for walking in the room and the corridor. Review of post fall IDT documentation, and nurses notes showed the resident had 7 falls from 5/1/14 to 7/8/14. Further review of the 5/6/14, 6/4/14, 6/13/14, 6/27/14, and 7/4/14 IDT post fall reviews showed the activity at the time of the falls was; "unassisted ambulation", and "unsteady gait." Review of the 7/8/14 timed at 6 PM nurses note showed the resident was "found on the floor in the hallway", no injuries were noted. Review of a 9:30 PM nurses note that same day showed the resident was "found on floor in [his/her] room" no injuries were noted. The following concerns were identified: a. Observation on 7/9/14 at 3:29 PM showed the resident lived in the secured unit of the facility. The resident wore a wanderguard device and was ambulating without assistance in the	F 323	F 323 Free of Accident Hazards/Supervision/Devices The facility will strive to ensure that the resident environment remains as fee of accidents hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: Resident #20: Supervision is provided by staff 24 hours a day. Activity staff/program added providing activities for resident's from 7 am - 9 am and 1pm to 8pm daily. Department managers are assigned to the lunch meal time to assist with resident supervision on 7/7/14 and ongoing. Resident #20 care plan has been updated with current assist device - wheelchair. She is currently being treated by the therapy dept. Additionally, resident #20's fall risk was reviewed by the interdisciplinary team and care plan was reviewed and updated. Resident #37: Supervision is provided by staff 24 hours per day. Activity staff/program added providing activities	

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F 323	Continued From page 13 television area and the hallway. The resident was noted to be unsteady on his/her feet, and had a hunched over posture. At 3:33 PM when the CNA noticed the resident was walking down the hall, she re-directed the resident to a seat. b. Review of the 6/30/14 care plan approach showed "walker available for resident to use PRN [as needed]." During the 7/9/14 observation, there was not a walker in the area for the resident's use. Interview with the unit manager on 7/9/14 at 5:25 PM revealed the resident doesn't use the walker, she was uncertain the reason why. c. Review of the 3/4/14 care plan for falls showed new interventions were added with occurrence of falls; however, there was not an intervention or approach that showed how staff were to supervise the resident when s/he was ambulating. 2. Review of the 5/13/14 admission MDS assessment showed resident #37 was severely cognitively impaired with a BIMS score of 3. Further, the resident had behaviors to include wandering which occurred daily and used a walker for ambulation. S/he was unsteady but able to stabilize him/herself. The Nursing Admission Intake Form dated 5/2/14 showed the resident had a walker but would forget to use it. The following concerns were identified: a. Review of the falls documentation for the resident showed s/he had fallen once in May 2014, 4 times in June 2014 and once in July 2014. Of these 6 falls, 4 were unwitnessed. b. Observation on 7/8/14 at 9:55 AM showed the resident was in the hallway without a walker. There were no staff observed in the area at that time. The resident had pulled down his/her pants and attempted to walk. S/he then pulled up the pants, stumbled and grabbed a surveyor who was	F 323	for resident's from 7am - 9am and 1pm to 8pm daily. Department managers are assigned to the lunch meal time to assist with resident supervision on 7/7/14 and ongoing. Care plan was updated to reflect current assisted device. Pharmacist Consultant reviewed medication on 7/23/14. Physician discontinued Haldol on 8/1/14. Physician will see resident for rounds on 8/7/14 to assess resident and further review his meds. Additionally, resident #37's fall risk was revised by the interdisciplinary team and care pan reviewed and updated. Identification of Others: Falls on the Courtyard neighborhood will be trended for the past month in relation to staffing and activities and mealtimes by the DON/designee. The IDT will review Resident #22 staff/program added providing activities Supervision is provided by staff 24 hours per day. Activity for resident's from 7am - 9am and 1pm to 8pm daily. Department managers are assigned to the lunch meal time to assist with resident supervision on 7/7/14 and ongoing. Pharmacist Consultant reviewed medication on 7/23/14. Flexeril was discontinued on 6/26/14. Additionally, resident #22's fall risk was reviewed by interdisciplinary team and care plan reviewed and updated. Resident last fall was 6/25/14. these trends and adjust staffing, activities and Department Manager Meal supervision according to these trends on or before the date of compliance. The interdisciplinary team will review fall risk	

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F 323	Continued From page 14 in the area. CNA #2 then came down the hallway from a room and took the resident to the bathroom. The CNA indicated the resident was to use a walker or wheelchair for locomotion. In addition, the resident had been sitting in a recliner and the motion sensor was located on the wheelchair and not attached to the resident. Interview with CNA #3 on 7/9/14 at 12:40 PM revealed the alarm was to be attached to the resident while in the recliner. Further, he revealed the resident would remove the alarm and dismantle it. c. The care plan for falls, last reviewed on 7/7/14, showed an alarm was to be used while the resident was sitting in the recliner. It did not indicate the resident periodically removed the alarm him/herself. Further, it showed the staff was to observe for potential patterns of falls to identify possible causes. There were no identified causes indicated on the care plan. The staff was also to place frequently used items within reach of the resident, it did not indicate what those items were to include the walker. d. Review of the MAR for June 2014 showed the resident received the following medications routinly; Butrans patch for pain, Remeron for depression, and Latuda for mood swings. In addition, the resident received Haldol and Ativan for agitation as needed. Side effects of the these medications included sedation, vertigo, dizziness, weakness and confusion. There was no documentation to show an analyses was completed to determine if the medication side effects may have contributed to the falls. 3. Review of the 5/19/14 annual MDS assessment for resident #22 showed s/he was severely cognitively impaired with a BIMS score of 3. Further, s/he had wandering behaviors that	F 323	and review and update care plans as needed for residents who reside on Courtyard. Residents with elopement risk care plans were reviewed and updated with any changes. Systemic Changes: Education will be provided by the SDC/Designee to the staff who work on Courtyard on fall prevention before the date of compliance. DON/Designee will complete weekly random observations of mealtimes in the Courtyard unit and review with IDT at morning meeting Monday through Friday. The Interdisciplinary Team will review all falls that occurred on the prior day each morning at the business meeting Monday through Friday noting time of fall and behaviors and whether witnessed or not witnessed and adjust activity/staffing if the IDT determines there is a need for the change. The nurses station will be relocated to the resident room across from the day room of the Courtyard unit on or before the date of compliance to increase supervision of residents. Monitor: The Quality Assurance and Performance Improvement Committee meets monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to facility QAPI Committee which will evaluate the effectiveness of the plan based on trends	

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F 323	Continued From page 15 occurred daily and had a history of falls with injuries. The resident used a walker with ambulation. The following concerns were identified: a. Review of the Interdisciplinary Post Fall Reviews showed the resident fell 8 times between 4/2/14 and 6/25/14. Seven of the eight falls were unwitnessed with 6 resulting in injuries to include skin tears, minor bruising, minor head injuries, and a fracture of the lumbar region of the back on 4/2/14. b. Review of the care plan for falls last reviewed on 7/3/14 showed the resident was to be observed for potential patterns of falls to identify possible causes, none were identified. Further review showed interventions included keeping frequently used items within reach. It did not include what items were to be within reach for this resident. c. Review of the May through June 2014 MARs showed the resident routinely received a fentanyl patch for pain and hydrocodone-acetaminophen for pain as needed and Flexeril for muscle spasticity as needed. Side effects included dizziness, ataxia (defective muscular coordination), and sedation. The care plan for falls showed the staff was to observe for any potential medication related causes. Review of the post fall reviews showed that narcotics may have contributed to the falls but there was no documentation to show an analyses of their use and how they may have correlated with the falls. 4. An interview with CNA #2 on 7/8/14 at 9:50 AM revealed there was not enough staff to monitor all the residents particularly during meal times due to resident behaviors. The staff attempted to keep the residents in the dining room until everyone had completed their meals. If the residents did	F 323	identified and implement additional interventions as needle to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	

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F 323	Continued From page 16 leave the dining room, one of the two CNAs would attempt to periodically check on those residents who had left during the meal. 5. During an interview with unit manager #1 on 7/8/14 at 5:15 PM, she acknowledged there was not enough supervision of residents on the secure unit, especially during the later afternoon and evening hours when the residents became more active. Further, she indicated interventions for falls and behaviors needed to be better developed. 6. Interview with the DON and the administrator on 7/10/14 at 11:50 AM revealed the facility had identified a need for increased supervision and resident engagement in the secure unit. The facility had started to implement a system begining in July 2014 to increase activity personnel and managers in the evenings to spend time with the residents while nursing staff were busy providing cares in resident rooms.	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		8/20/14

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F 329	Continued From page 17 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 medications for 1 of 14 sample residents (#37). The findings were: Review of the 6/13/14 admission MDS assessment showed resident #37 had diagnoses to include depression and dementia with behaviors. The behaviors included those that would put others at significant risk for physical injury, intrude on the privacy or activities of others and disrupt care or living environment. Review of the June and July 2014 MAR showed the resident was prescribed the following antipsychotic medications; Haldol 2-5 mg intramuscularly (IM) or orally every 6 hours as needed for agitation, Ativan 1 mg as needed for anxiety, Latuda 20 mg daily for dementia with behaviors and Remeron 7.5 mg daily for depression. The following concerns were identified: a. Review of the June 2014 nurses' notes for Haldol administration showed the resident received nine 2 mg oral doses of the medication,	F 329	F 329 Drug Regimen is Free from Unnecessary Drugs The facility strives to ensure that 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 the 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. Corrective Action: Resident #37's order for prn haldol was discontinued on 8/1/14. Resident has order for Ativan 1 mg BID prn for anxiety -	

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F 329	Continued From page 18 three 2.5 mg oral doses, and one 5 mg dose. Further, s/he received three 5 mg doses IM and one 2.5 mg dose. Further, the reasons documented for administrating the medication was in part for agitation and anxiety. In addition, the resident received two doses of Ativan for agitation. Review of the physician orders dated 6/11/14 showed Haldol was to be given for agitation 2-5 mg IM or by mouth. It did not indicate what level of agitation the medication was to be given for and under what circumstances and what dose. It also did not clearly define the use of Ativan versus Haldol, both given for agitation. b. Review of the physician orders dated 7/2/14 showed the medication Latuda was ordered for dementia with behaviors. The Psychoactive Medication Consent form dated 6/10/14 revealed the medication was ordered for behaviors to include mood swings and manic-depressive type behaviors. Review of the indications and usage for Latuda at drugs.com (accessed on 7/16/14), an FDA prescribing information site, showed the medication was prescribed for patients with schizophrenia and bipolar depression. The resident had the diagnosis of dementia with behaviors and depression and not schizophrenia or bipolar depression. Further, a warning was issued that stated; "INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS; AND SUICIDAL THOUGHTS AND BEHAVIORS." The resident was also prescribed the medication Remeron for depression. c. Review of a communication from the pharmacist to the physician dated 6/23/14 showed; "The resident is receiving the antipsychotic agent Latuda and Haldol, but lacks an allowable diagnosis to support its use." There	F 329	behaviors specific to this resident are breaking windows, tearing apart equipment, breaking items, and hitting. The physician reviewed his medication and diagnoses on 7/3/14. The physician progress note states that Resident #37 has improved on Latuda. Resident #37 physician was contacted regarding request for review of psychotropic medications on 7/25/14 per pharmacist consultant review. The pharmacist consultant note to physician requested a risk vs. benefits statement on the use of Latuda. The physician will assess resident #37 and review psychotropic medications and behaviors that put himself and others at risk for injury. Resident #37 care plan for latuda and ativan has been reviewed and revised with dosage/frequency, specific behaviors and effective resident specific non-medicinal approaches. IDT reviewed meds, diagnoses, psychotropic quarterly assessments, risk/benefit statements, non-pharmacological approaches, pharmacist consultant recommendations, care plans and consents and updated as necessary. Identification of Others: A list of resident's receiving psychotropic medications and corresponding diagnoses with be reviewed by the DON/designee. Any resident who is found to not have an appropriate diagnoses and/or range orders or dual medications will have their physician contacted for medication review/change and/or risk vs benefits	

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F 329	Continued From page 19 was no documentation to show the physician had seen the communication as of 7/10/14. An interview with the pharmacist on 7/10/14 at 10:30 AM confirmed dementia with behaviors was not an appropriate diagnoses for the use of the medication Latuda. Further, he indicated Haldol would not be recommended to treat the resident's behaviors. d. During an interview with RN #1 on 7/9/14 at 9:20 AM, she indicated the use of Haldol would only be used if the non-pharmacological interventions and Ativan didn't work for the resident's behaviors. She also determined the amount of the Haldol to be used was dependent on the severity of the behaviors. Review of the nurses' notes showed the Haldol was used as an initial approach more so than the Ativan. e. Review of the care plans for the psychoactive medications Latuda and Haldol failed to specify how, when, and what dose the Haldol was to be used. Further, it did not indicate what non-pharmacological interventions were found to be effective or address preventive measures for behaviors specific to the resident.	F 329	statements. The DON/designee will review care plans for residents receiving psychotropic medications to ensure care plans contain dose/frequency and resident specific non-medicinal approaches as well as specific behaviors and diagnoses. Findings of the audits will reviewed in the am business meetings Monday through Friday. Systemic Changes: The IDT will review physician telephone orders and the 24 hour report in the am business meetings and revise and update care plans as needed. If there are new or changes in existing psychotropic medication orders review will include checking for duplicative therapy, diagnosis and parameters and symptoms for PRN use. The MDS Coordinator will verify that care plans for psychotropic medications contain appropriate diagnoses, dose, frequency, specific behaviors and resident specific non-medicinal interventions. During care conferences quarterly, annually and with change of conditions. Pharmacy consultant recommendations will be reviewed by DON/designee monthly to check for follow up on any recommendations. The IDT will meet with the pharmacist consultant quarterly on each resident who receives psychotropic drugs to review diagnoses, dosage, behaviors and non-medicinal approaches and communicate with physician regarding possible medication reductions. Monitor:	

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F 329	Continued From page 20	F 329	The Quality Assurance and Performance Improvement Committee meets monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by was of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353		8/20/14

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F 353	Continued From page 21 duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, and review of the nursing schedule, the facility failed to ensure adequate staffing to supervise the needs of residents on 1 of 4 nursing units (Courtyard). Three of 4 sample residents (#20, #22, #37) who were at risk for falls and resided in that unit were not adequately supervised to prevent falls. The findings were: Review of the nursing schedule for June and July 2014 showed there were regular shifts scheduled for CNAs and for licensed nurses. The courtyard unit (a secured dementia unit) had a total of 20 residents, and 17 of these 20 had behaviors that included wandering. The unit was designed with a nurses' station at one end, a dining room which was kept closed except for meals or special activities, and a common area for residents to congregate which was on the other end of the hall from the nurses' station. Review of the nursing schedule showed 2 CNAs were on duty until 10 PM, and there was also one licensed nurse on each shift. At 10 PM there was one CNA and one nurse scheduled. Periodic observation on 7/7/14, 7/8/14, and 7/9/14 on the day (6AM- 6PM), and evening shifts (6PM-10 PM) showed the nursing schedule was followed. In addition, activity staff and managers were periodically in the unit to provide activities and supervision. The following concerns were identified: a. Review of fall documentation from 6/1/14 to 7/8/14 showed residents #20, #22, and #37 had frequent falls. The total number of falls for these residents during that period was 19 with 10	F 353	F 353 Sufficient 24-Hr Nursing Staff Per Care Plans The facility strives to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident, as determined by resident assessments and individual plans of care. Corrective Actions: Resident #20 is supervised by nursing staff 24 hours a day. Activity staff/program added and providing activities for resident's from 7am - 9am and 1pm to 8pm daily. Department managers are assigned to the lunch meal time to assist with resident supervision on 7/7/14 and ongoing. Resident #22 Activity staff/program added and providing activities for resident's from 7am - 9am and 1pm to 8pm daily. Department managers are assigned to the lunch meal time to assist with resident supervision on 7/7/14 and ongoing. Resident #37. Activity staff/program added and providing activities for	

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F 353	Continued From page 22 of the falls unwitnessed by staff. The July 2014 falls for these residents occurred on 7/4/14, 7/5/14 and two falls on 7/8/14 for resident #20. b. Interview with a family member of resident #36 on 7/7/14 at 5:45 PM revealed the facility did not provide enough staff to monitor the residents, especially during meals on the secured dementia unit. The residents were allowed to wander in the hallways unsupervised after they had finished their meal because staff remained in the dining room assisting and supervising those that remained. Further, she indicated there weren't enough activities to keep the residents engaged during the evening hours. c. An interview with CNA #2 on 7/8/14 at 9:50 AM revealed there was not enough staff to monitor all the residents particularly during meal times due to resident behaviors. The staff attempted to keep the residents in the dining room until everyone had completed their meals. If the residents did leave the dining room, one of the two CNAs would attempt to periodically check on those residents who had left during the meals. d. During an interview with unit manager #1 on 7/9/14 at 5:15 PM, she acknowledged there was not always enough staff to supervise the residents on the secure unit especially during the later afternoon and evening hours. At that time, she said residents displayed more disruptive behaviors and wandering which increased the need for more engaging activities. e. Interview with the DON and the administrator on 7/10/14 at 11:50 AM revealed the facility had identified a need for increased supervision and resident engagement in the secure unit. The facility had started to implement a system beginning in July 2014 to increase activity personnel and managers in the evenings to spend time with the residents while nursing	F 353	resident's from 7am - 9am and 1pm to 8pm daily. Department managers are assigned to the lunch meal time to assist with resident supervision on 7/7/14 and ongoing. Identifications of Others: Falls and behaviors in the Courtyard will be trended for the past month in relation to staffing and activities and mealtimes by the DON/designee. The IDT will review these trends and adjust staffing, activities and Department Manager Meal supervision according to these trends on or before the date of compliance. Systemic Changes: DON/Designee will complete weekly random observations of mealtimes in the Courtyard unit and review with IDT at morning meeting Monday through Friday. The Interdisciplinary Team will review all falls and behaviors that occurred on the prior day each morning at the business meeting Monday through Friday noting time of fall and behaviors and whether witness or not witness and adjust activity/staffing if the IDT determines there is a need for the change. The nurses station will be relocated to the resident room across from the day room of the Courtyard unit on or before the date of compliance to increase supervision of residents. Monitor: The Quality Assurance and Performance Improvement Committee meets monthly to address noted trends and patterns	

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F 353	Continued From page 23 staff were busy providing cares in resident rooms.	F 353	through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of temperature logs, the facility failed to ensure food was maintained at required temperatures for safety. In addition, the facility failed to ensure a sanitary environment in the kitchen related to the condition of walls and floors. The findings were: 1. Observation of the evening meal preparation and service on 7/8/14 at 4:15 PM showed the menu included beef stir fry with rice. Cook #1	F 371	F 371 Food, Procure, Store/Prepare/Serve-Sanitary The facility strives to store, prepare, distribute and serve food under sanitary conditions. Corrective Actions	8/20/14

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F 371	Continued From page 24 took the pan of beef stir fry out of the oven at 4:30 PM and took the temperature which was recorded as 185 degrees Fahrenheight (F). At 4:38 PM the cook scooped some of the beef stir fry into a separate pan and used a food processor to create a pureed texture of the food. The pureed food was placed in the pan onto the steamtable, and a temperature was not taken. The following concerns were identified: a. At 4:45 PM server #1 was starting to dish up food onto plates for the residents. Review of the temperature log located in the cooks area showed there was no temperature recorded for the pureed stir fry. At that time a temperature was requested and when cook #1 measured the temperature, the reading was observed to be 120 degree F. b. The cook stated the food needed to be reheated and put the pan into a steam oven. At 5:05 PM the temperature was taken and showed the pureed food was 135 degrees F. c. Review of the 7/8/14 temperature log showed the food was reheated to a temperature of 140 degrees F. In addition, the temperature log for the fist 8 days of July 2014 showed 6 of the 8 days when there were no temperature recordings for any foods served at the evening meals. d. Interview with the registered dietitian on 7/9/14 at 12:20 PM verified the temperature of the food should be taken prior to service and the re-heated pureed food should have been re-heated to a temperature of 165 degrees F. According to Food Code 2013, U.S. Public Health Service, 3-403.11 Reheating for Hot Holding. "(A) Except as specified under ¶¶ (B) and (C) and in ¶ (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be	F 371	Cook #1 will be educated 1 on 1 on procedure for obtaining and documenting food temperatures and proper serving temperatures for food, including pureed food. The floors in the kitchen will be deep cleaned by designated staff to remove grime and grease buildup before date of compliance. The walls in the kitchen will be inspected and cleaned as needed by dietary staff or designee before date of compliance. Any areas identified as needing repairs or painting will completed by Maintenance Director or designee before date of compliance. Identification of Other All facility residents have the potential to be affected by kitchen sanitation and food temperatures. Systemic Changes Dietary staff will be educated by Food Service Manager or designee before date of compliance on procedure for taking and documenting food temperatures. The education will include proper serving temperatures. The Food Service General Manager or designee will complete random audits of food temperatures, including pureed and proper documentation of temperatures at 6 meals weekly, including all 3 meals and weekends. Corrective actions will be taken as needed. The Food Service General Manager or designee will develop and implement a deep cleaning schedule for the kitchen which will include floors an walls before the date of compliance. Food service staff will be educated by Food	

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F 371	Continued From page 25 reheated so that all parts of the FOOD reach a temperature of at least 74oC (165oF) for 15 seconds." 2. Observation on 7/7/14 at 3:30 PM and 7/8/14 at 4:15 PM showed the kitchen floors around the edges of the walls throughout the kitchen were soiled with build-up of grease and grime. The wall behind the three compartment sink and behind the main steamtable were splattered with food and had chipped, peeling paint. Interview with the dietary manager on 7/9/14 at 9 AM verified the floors and walls were in need of deep cleaning, and a schedule was being prepared. According to Food Code 2013, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	F 371	Service General Manager or designee on kitchen sanitation, including the deep cleaning schedule. The Registered Dietician or designee will complete a kitchen sanitation review weekly. Corrective actions will be taken as needed. Monitor The Quality Assurance and Performance Improvement Committee meets monthly to address noted trends and patterns. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then reassess the need for continued monitoring based on compliance.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		8/20/14

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F 428	Continued From page 26 by: Based on medical record review, and staff interview, the facility failed to act on irregularities found during the drug regimen review for 1 of 14 sample residents (#37). The findings were: Review of the 5/13/14 admission MDS assessment for resident #37 showed s/he had diagnoses to include depression and dementia with behaviors. The behaviors included those that would put others at significant risk for physical injury, intrude on the privacy or activities of others and disrupt care or living environment. Review of the June and July 2014 MAR showed the resident was prescribed the following antipsychotic medications; Haldol 2-5 mg intramuscularly (IM) or orally every 6 hours as needed for agitation, Ativan 1 mg as needed for anxiety, Latuda 20 mg daily for dementia with behaviors and Remeron 7.5 mg daily for depression. The following concerns were identified: a. Review of the physician orders dated 7/2/14 showed the medication Latuda was ordered for dementia with behaviors. The Psychoactive Medication Consent form dated 6/10/14 revealed the medication was ordered for behaviors to include mood swings and manic-depressive type behaviors. Review of the indications and usage for Latuda at drugs.com (accessed on 7/16/14), an FDA prescribing information site, showed the medication was prescribed for patients with schizophrenia and bipolar depression. The resident had the diagnosis of dementia with behaviors and depression and not schizophrenia or bipolar depression. Further, a warning was issued that stated; "INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS; AND SUICIDAL THOUGHTS AND	F 428	F 428 Drug Regimen Review, Report Irregular, Act on The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports any irregularities to the attending physician, and the director of nursing, strives to ensure these reports are acted upon Corrective Action: Resident #37's physician reviewed his medications and diagnoses on 7/3/14. The physician progress note states that Resident #37 had improved on Latuda. Resident #37 physician was contacted regarding request for review of psychotropic medications on 7/25/14 per pharmacist consultant review. The pharmacist consultant note to physician requested a risk vs benefits statement on the use of Latuda for of Dementia with behavioral disturbance. PRN Haldol was discontinued on 8/1/14. The physician will assess resident #37 and review psychotropic medications on 8/7/14 during rounds. A psychiatric consult has been requested to review resident's medications and behaviors that put himself and others a risk of injury. Identifications of Others: A list of resident's receiving anti psychotic medications and corresponding diagnoses	

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F 428	Continued From page 27 BEHAVIORS." The resident was also prescribed the medication Remeron for depression. b. The pharmacy record of review showed the pharmacist had reviewed the resident's medications on 6/21/14 and did not indicate any concerns. However; review of a communication from the pharmacist to the physician dated 6/23/14 showed; "The resident is receiving the antipsychotic agent Latuda and Haldol, but lacks an allowable diagnosis to support its use." There was no documentation to show the physician had seen the communication as of 7/10/14. An interview with the pharmacist on 7/10/14 at 10:30 AM confirmed dementia with behaviors was not an appropriate diagnoses for the use of the medication Latuda. Further, he indicated Haldol would not be recommended to treat the resident's behaviors. The pharmacist further explained the process was for nursing staff to forward his recommendations to the physician to be acknowledged. c. During an interview with the medical records director on 7/9/14 at 5:50 PM, she acknowledged the pharmacist had completed the form indicating the need for an appropriate diagnosis for the use of Latuda and Haldol. Further, the expectation was that the physician would review the document when he came in to see the residents. An interview with the DON on 7/10/14 at 1:45 PM indicated she and the unit manager would normally receive the communications from the pharmacist.	F 428	with be reviewed by the DON/designee. Any resident who is found to not have an appropriate diagnoses will have their physician contacted for mediation review/change and/or risk vs benefits statements. The DON/designee will review pharmacist consultant notes for the past 60 days and any notes that have not received a response from the physician will be reported to the physician by the DON/designee. The DON/designee will use an audit tool to track pharmacist consultant notes, when they are communicated to the physician and when action by the physician is received. Finding of these audits will be reviewed in the am business meetings Monday through Friday. Systemic Changes: The DON/designee will review all pharmacist consultant reports when received and disperse to Nursing Administration Unit managers/designee to contact physicians for medication irregularities. The DON/designee will use an audit too to track pharmacist consultant notes, when they are communicated to the physician and when action by the physician is received. Findings of these audits will be review in the am business meetings Monday through Friday. The DON/designee will review any pharmacist consultant notes that have not had a response in the morning business meeting Monday thru Friday to ensure all medication irregularities are addressed in a timely manner. The IDT will meet with the	

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F 428	Continued From page 28	F 428	pharmacist consultant monthly to review residents receiving psychotropic medications including corresponding behaviors, dosage, and diagnoses. Any irregularities will be reported to the physician by the DON/designee. Monitor: The Quality Assurance and Performance Improvement Committee meets bi-monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility AQPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		8/20/14

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F 441	Continued From page 29 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to ensure infection control measures were followed for incontinence care during 1 of 3 observations of resident care (#37). The findings were: Observation on 7/8/14 at 9:55 AM showed CNA #2 walked with resident #37 to the bathroom. The CNA removed the incontinence pad and cleansed the resident's posterior perineum and then the anterior perineum using the same wipe. The CNA	F 441	F 441 Infection Control, Preven Spread, Linens The facility strives to establish and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	

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F 441	Continued From page 30 then removed her gloves after providing incontinence care and proceeded to assist the resident to include repositioning the wheel chair without first cleansing her hands. Review of the 5/13/14 admission MDS assessment showed the resident required extensive assistance with toileting and personal hygiene. Further, the resident had diagnoses to include chronic kidney disease. Review of the policy and procedure for perineal care dated 10/4/13 showed the anterior perineum was to be cleansed first then the posterior perineum. Further, it showed following the care, gloves were to be removed and hand hygiene performed. An interview with unit manager #1 on 7/10/14 at 10:10 AM confirmed the CNA should cleanse the front of the resident first then the posterior perineum. Further she needed to cleanse her hands immediately after removing the gloves and before continuing with other tasks.	F 441	Corrective Action: CNA #2 received education regarding hand washing during incontinence care and Perineum Care on 7/8/14 after initial observation. Resident #37 received perineum care on 7/8/14 after initial observations and ongoing. Identification of Others: A review of documentation of residents requiring assistance with peri care will be completed by DON/designee. The SDC/designee will complete 6 random peri care observations and report to IDT every am at the business meeting Monday through Friday. If peri care hand washing procedure discrepancy occurs the SDC/designee will provide immediate education and corrective action. Systemic Changes: Nursing staff will be educated on proper peri care technique and handwashing by the SDC/designee prior to date of compliance. DON/designee will complete 6 weekly random observations of peri care and and hand washing and provide immediate in-servicing and corrective action at the time of the observation. Results of observations will be reviewed with IDT at morning meetings Monday through Friday. SDC/designee will provide education on or before the date of compliance for all licensed staff on providing proper peri care and hand washing procedure while providing peri care.	

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F 441	Continued From page 31	F 441	Monitor: The Quality Assurance and Performance Improvement Committee meets monthly to address noted trends and patterns through a number of clinical operations systems as necessary. Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QAPI committee which will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance for 4 months then re-assess the need for continued monitoring based on compliance.	