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

PRINTED: 11/21/2014
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
	53A002	A. BUILDING _____ B. WING _____	11/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

(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: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set PT- Physical Therapy RN- Registered Nurse 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 and staff and resident interview, the facility failed to promote dignity related to dining during one random observation which affected resident #21. The findings were: Observation on 11/5/14 at 12:15 PM showed resident #21 came into the dining room to get the attention of staff related to his/her meal. The resident was overheard asking dietary staff #1 why s/he did not receive the regular size portion	F 241	Amie Holt Care Center will 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 will be accomplished by: A) To prevent emotional distress, resident #21 will be served her meals as ordered. B) The Dietary Manager (DM), with assistance from the Registered Dietitian (RD), will review and adjust the diet information sheet/tray cards to correspond with the physician's orders of all residents to assure appropriate items, including portion sizes and enhancements are provided. The DM and RD will review and update as needed the current policy and procedure on Diet Fortification. C) The dietary staff will be educated by the DM, with assistance from the RD, by an in-service on regular and therapeutic diets including portion sizes, tray card use, and appropriate fortification techniques with (continued on next page)	12/20/2014

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

CEO — 12/2/14

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.

DEC 02 2014

Accepted with changes 12/9/14 1:10 PM Risa Dwiggins

Healthcare Licensing and Surveys

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F 241	Continued From page 1 of the protein part of the meal. The resident pointed out the meals at one table where residents were eating, and stated "see they got more chicken than me." The staff member was new and in trying to help the resident referred the question to the person serving the meals. A few minutes later the resident was observed seated in the lounge outside of the dining room crying. Interview with the resident at that time revealed s/he was frustrated at the "constant struggle" of having to ask to get the meal served correctly. The resident further revealed s/he ate meals in the lounge because it "upset" him/her to see what others were getting in the dining room. The resident further explained s/he was diabetic and had small portions except for a regular size portion of the protein at each meal to help in the control of his/her blood sugar. Review of the planned menu showed "stuffed chicken thigh" was the protein in the meal and 6 ounces was the planned regular size portion. Observation of the noon meal service at 11:35 AM showed the 6 ounces was served by providing two pieces of the chicken. Observation of the resident's chicken portion which s/he stated was left untouched showed 1 piece of the chicken. Interview with the DON on 11/5/14 at 5 PM stated the resident had brought this issue up on 10/31/14 and she had talked with the dietary manager on that day. The DON verified the resident was to get the regular portion size for protein and she thought the issue had been corrected. The DON then stated the resident should not have to repeatedly ask staff to make it right.	F 241	Continued From page 1 written material provided as needed including our policy and procedure on "Diet Fortification". New employees will be oriented to this process during orientation. The DM or designee will update the diet information sheet/tray cards when new diet orders are received. D) The DM or designee will review the diet information sheet/tray cards corresponding to the physician's orders of all residents monthly x3 months then quarterly. This will be presented and reviewed at the facility QAPI meeting to help identify trends and need for further education or monitoring. The DM or designee will monitor 10 trays a week x3 months, then 10 trays monthly and report on tray accuracy, including diet fortification appropriateness. This will be presented and reviewed at the facility QAPI meeting to help identify trends and need for further education or monitoring.	

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F 241	Continued From page 2	F 241		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	The facility will conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment conducted of each resident's functional capacity. This will be accomplished by: A) Resident #37 has pasted away. Care Area Assessments for residents #24, #34, #32, #4, #9, #35 will be reviewed and revised to include analysis of problems, needs or strengths related to the triggered areas. An RN will be involved in this assessment process. B) CAAs for each resident will be reviewed and revised as neededin the same manner at the time his/her quarterly MDS is due. C) Members of the IDT involved in completion of MDS, CAA, or care planning paperwork will read the Care Area Assessment Process and Care Planning Chapter in the Resident Assessment Instrument User Manual. This will include the Nurses Team Leaders, MDS Coordinator, DON, MSS, Activities Director, and Dietary Manager. D) A Performance Improvement Tool will be developed by the DON to ensure CAAs are completed appropriately. This will be completed monthly by the DON or designee and reported quarterly to the PI committee.	12/20/2014

RD RN

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F 272	Continued From page 3	F 272		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of triggered areas for 7 of 10 sample residents (#4, #9, #24, #32, #34, #35, #37). The findings were:

1. Review of the 10/14/14 annual MDS assessment showed resident #24 triggered on section V of the MDS assessment for areas including: visual function, urinary incontinence and indwelling catheter, falls, activities, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcer, psychotropic drug use, and pain. These triggered areas required additional evaluation and comprehensive assessment. Review of the CAAs for these areas showed dental care was not addressed at all. The other CAAs failed to include an analysis of the resident's problems, and needs or strengths related to these areas. The information included mostly data and was without analysis and assessment. Continued review showed an interdisciplinary decision making process was not evident in the CAA which was utilized for care planning.

2. Review of the 11/13/13 admission MDS assessment showed resident #34 triggered on section V of the MDS assessment for areas that included: cognitive loss, visual function, communication, urinary incontinence and

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F 272	Continued From page 4	F 272		

indwelling catheter, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, psychotropic drug use, and pain. These triggered areas required additional evaluation and comprehensive assessment. Review of the CAAs showed they failed to include an analysis of the resident's problems, and needs or strengths related to these areas. The information included mostly data and was without analysis and assessment.

3. Review of the 1/17/14 significant change MDS assessment, section V showed resident #32 triggered for the following areas requiring further assessment: Visual function, communication, ADL function, urinary incontinence and indwelling catheter, psychosocial well-being, activities, falls, nutrition, dental care, psychotropic drug use, and pain. Review of the CAAs showed they failed to be comprehensive, and did not include an analysis of the resident's problems, and needs or strengths related to these areas. The information included mostly data and was without analysis and assessment. Continued review showed an interdisciplinary decision making process was not evident in the CAA which was utilized for care planning.

4. Review of the 10/26/14 admission MDS assessment, section V for resident #4 showed triggered areas requiring further assessment included: Cognitive loss, ADL function, and urinary incontinence. Review of the CAAs for these areas showed the following concerns:

a. Review of the CAA assessment for cognitive loss showed it was not comprehensive it only information was, "Res [resident] triggers for cognitive loss and Dementia-d/t [due to] Alzheimer's Dementia."

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F 272	Continued From page 5	F 272		

b. Review of the CAA for ADL function showed it was contradictory and not comprehensive, the information showed the resident received extensive assistance with his/her care but functioned at a high level. Further, it showed the resident was unable to walk or self-transfer. However, it also showed the resident was able to stand and pivot with assistance.

c. The CAA assessment completed for urinary incontinence showed the resident was incontinent at times. Further, the resident was able to transfer and walk to the bathroom with a walker. The 10/26/14 MDS assessment, section G, showed the resident required extensive assistance with transfers and locomotion. In addition, the CAA showed the resident was incontinent due to stress incontinence and dementia. Review of the MDS assessment, section H, showed the resident was frequently incontinent of urine and was on a toileting program.

d. The CAAs did not provide additional information that was not found in the MDS assessment. The assessments were not comprehensive and did not include any complicating factors or risks associated with the care areas. Further, the MDS assessment and the CAA contained conflicting information.

5. Review of the admission MDS assessment dated 7/20/14 revealed resident #9 triggered on section V of the MDS assessment for areas including: cognitive loss, communication, ADL function, psychosocial well being, activities, falls, nutritional status, pressure ulcers, and psychotropic drug use. These triggered areas required additional evaluation and assessment. Review of the CAAs showed cognitive loss and

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F 272	Continued From page 6	F 272		

psychotropic drug use were not addressed at all. The other area CAAs failed to include an analysis of the resident's problems, needs, weaknesses or strengths related to these areas. The information included mostly data and was without analysis and assessment. Continued review showed an interdisciplinary decision making process was not evident in the CAA which was used for care planning.

6. Review of the annual MDS assessment dated 5/18/14 revealed resident #35 triggered on section V of the MDS assessment for areas including: cognitive loss, visual function, communication, ADL function, urinary incontinence, behavioral symptoms, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcers, psychotropic drug use, and pain. These triggered areas required additional evaluation and assessment. The CAAs failed to include an analysis of the resident's problems, needs, weaknesses, or strengths related to these areas. The information included mostly data and was without analysis and assessment. Continued review showed an interdisciplinary decision making process was not evident in the CAA which was used for care planning.

7. Review of the admission MDS assessment dated 10/19/14 revealed resident #37 triggered on section V of the MDS assessment for areas including: cognitive loss, visual function, communication, urinary incontinence, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcers, and pain. These triggered areas required additional evaluation and assessment. The CAAs failed to include an analysis of the resident's problems, needs,

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F 272	Continued From page 7 weaknesses or strengths related to these areas. The information included mostly data and was without analysis and assessment. Continued review showed an interdisciplinary decision making process was not evident in the CAA which was used for care planning. 8. Interview with the DON on 11/21/14 at 9:20 AM verified the CAAs were not comprehensive assessments. According to the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual version 3.0, October 2014, Chapter 4: "The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths."	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278	The facility will ensure that assessments accurately reflect the resident's status by: A) 1) On 11/17/2014 a Quarterly MDS was completed for resident #35. It was coded correctly as resident having no restraint and not using oxygen. 2) Resident #37's most recent MDS on 10/19/2014 is coded accurately, indicating that this resident has no restraints. 3) Resident #40 had a change of condition MDS completed 11/17/2014. Section G was coded accurately, indicating extensive assistance is required by one person.	12/20/2014

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F 278	Continued From page 8 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of the MDS assessment for 3 of 10 sample residents (#35, #37, #40). The findings were: 1. Review of the quarterly MDS assessment dated 8/17/14 revealed resident #35 had diagnoses that included anxiety, depression, End Stage Renal Disease (ESRD), non-Alzheimer's dementia, and morbid obesity; and was severely cognitively impaired. Further review revealed the resident needed extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing; and was coded for use of a restraint when out of bed. Review of the annual MDS assessment dated 5/18/14 showed the resident was coded as using oxygen. The following concerns were noted:	F 278	Continued From page 8 B) All facility staff involved in the MDS process will be educated that all residents have the potential to be affected by inaccurate coding of the MDS. C) All future quarterly and full MDS's will be completed on paper by the Nurse Team Leaders, then entered into the computer by the MDS coordinator, who will assist in watching for inaccuracies. Any questionable coding will be reviewed and discussed with the Team Leader for clarification. D) A PI tool will be implemented to ensure accuracy of MDS coding. This will be completed monthly and reported quarterly to the Performance Improvement Committee.	

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F 278	Continued From page 9 a. Observation on 11/4/14 from 9:08 AM to 12:10 PM showed the resident in his/her wheelchair used a seat belt for positioning, and not as a restraint. b. Interview on 11/5/14 at 2 PM with LPN #1 revealed the seat belt positioning device was coded incorrectly as a restraint on the quarterly MDS assessment. c. Review of the medical record showed no evidence the resident used oxygen during the annual MDS assessment 7 day look back period. d. Interview on 11/6/14 at 1:30 PM with LPN #1 revealed the use of oxygen was coded incorrectly on the annual MDS assessment. 2. Review of the admission MDS assessment dated 10/19/14 revealed resident #37 had diagnoses that included non-Alzheimer's dementia, and was severely impaired. Further review revealed the resident needed extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Review of the quarterly MDS assessment dated 7/20/14 revealed the resident was coded as using two restraints when out of bed. Review of the care plan revealed the resident used a seat belt as a positioning device. There were no notes in the medical record to show the seat belt was a restraint, nor did it reveal any other restraint was utilized for this resident. Interview on 11/6/14 at 1:30 PM with LPN #1 verified the seat belt positioning device was coded incorrectly as a restraint in the quarterly MDS assessment. 3. Review of the 10/6/14 quarterly MDS assessment, section G, showed resident #40 required only limited assistance with toilet use, personal hygiene and bathing. Further, it showed the resident required physical assistance of 2 or	F 278		

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F 278	Continued From page 10 more persons. During an interview with RN #1 on 11/6/14 at 12:50 PM, she revealed the assessment was inaccurately coded. She stated the resident would not require the assistance of two persons being coded as requiring limited assistance.	F 278		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure professional standards were met related to completion of various nursing assessments for 6 of 10 sample residents (#4, #9, #24, #34, #35, #37). The findings were: 1. Review of the 10/14/14 annual MDS assessment showed resident #24 triggered on section V of the MDS assessment for areas including: ADL function, urinary incontinence and indwelling catheter, dehydration/fluid maintenance, pressure ulcer, and pain. These triggered areas required additional evaluation and assessment. Review of the CAAs for these areas showed an LPN rather than an RN had completed these assessments. 2. Review of the 11/13/13 admission MDS assessment showed resident #34 triggered on section V of the MDS assessment for areas that	F 281	AHCC will ensure that services provided or arranged by the facility meet professional standards of quality by: A) Res. #37 has passed away. CAAs will be reviewed and updated for the remaining residents (#4, #9, #24, #34, #35); an RN will be involved in the completion of these assessments. B) CAAs for all residents will be reviewed and updated with the involvement of an RN as they are due for their quarterly reviews. C) DON will educate Nurse Team Leaders on the need for RNs to be involved in the analysis/-assessment of CAAs. D) DON will implement a tool to monitor that RNs are responsible for CAA assessments. This will be completed monthly and reported quarterly to the PI Committee.	12/20/2014

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F 281	Continued From page 11 included: urinary incontinence and indwelling catheter, dehydration/fluid maintenance, pressure ulcer, and pain. These triggered areas required additional evaluation and assessment. Review of the CAAs for these areas showed an LPN had signed as completing these assessments. In addition, the resident was assessed by an LPN for the use of a positioning device on 3/21/14. 3. Review of the 10/26/14 admission MDS assessment, section V, for resident #4 showed triggered areas included ADL function, urinary incontinence, dehydration and pressure ulcers. Further review of the "typed sheet" referred to in section V for CAA assessments, showed they were completed by an LPN and not an RN. 4. Review of the admission MDS assessment dated 7/20/14 revealed resident #9 triggered on section V of the MDS assessment for areas including: ADL function and pressure ulcers. These triggered areas required additional evaluation and assessment. Review of the CAAs for these areas showed an LPN rather than an RN had completed these assessments. 5. Review of the annual MDS assessment dated 5/18/14 revealed resident #35 triggered on section V of the MDS assessment for areas including: ADL function, urinary incontinence, dehydration/fluid maintenance, pressure ulcers and pain. These triggered areas required additional evaluation and assessment. Review of the CAAs for these areas showed an LPN rather than an RN had completed these assessments. 6. Review of the admission MDS assessment dated 10/19/14 revealed resident #37 triggered on section V of the MDS assessment for areas	F 281		

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	53A002	A. BUILDING _____ B. WING _____	11/07/2014

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F 281	Continued From page 12 including: urinary incontinence, falls, dehydration/fluid maintenance, pressure ulcers, and pain. These triggered areas required additional evaluation and assessment. Review of the CAAs for these areas showed an LPN rather than an RN had completed these assessments. 7. Interview with LPN #1, the MDS coordinator, and the DON on 11/5/14 at 2:07 PM verified the LPN was a nursing team leader and completed many of the CAA analysis for residents. They were unaware completing this portion of the MDS assessment process was not within her scope of practice. According to the Wyoming State Board of Nursing Advisory Opinion titled "LPN and RN Scope of Practice" dated July 2014: RN standards related to scope. "7. A RN assigns and delegates nursing activities. The RN shall...b. Assign nursing care to a LPN with the LPN scope of practice based on the RN's assessment of the client and the LPN's ability." According to the Wyoming Nursing Practice Act of July 2006 and the Administrative Rules and Regulations of November 2003, a licensed practical nurse shall contribute to the nursing assessment by collecting, reporting, and recording objective and subjective data in an accurate and timely manner.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	The facility will ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistant devices to prevent accidents by:	12/20/2014

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F 323	Continued From page 13 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure lifts were used appropriately and in a safe manner for 1 of 3 sample residents (#18) observed during lift transfers. In addition, the facility failed to develop effective interventions following falls for 2 of 7 sample residents (#9, #35) with falls. The findings were: 1. Review of the 5/20/14 emergency note for resident #18 showed s/he was admitted for an examination after a fall. The resident complained of right hip pain and had injuries to include a skin laceration. X-rays were completed and showed no acute fractures. However, the radiology report showed the resident had a dislocated pin of the right hip that the physician contributed to the resident's chronic hip pain. Review of the discharge summary dated 8/29/14 showed the resident had sustained a left hip fracture after a fall on 8/21/14. Due to the age of the resident, the hip was not repaired. Further, it showed the resident had fractured his/her right hip the year before and treatment to repair the hip had failed. Review of the physical therapy note dated 8/30/14 showed the resident had complained of general pain and received routine pain medications but noted s/he remained in constant pain. The therapist documented the resident was able to	F 323	Continued From page 13 A) Resident #18's RN Team Leader will re-evaluate this residents abilities and safety with the use of the sit-to-stand lift (EZ Stand). Fall team will meet to discuss residents #9 and #35 to attempt to further analyze falls and explore new interventions to prevent further occurrences. B) Nurse Team Leaders will observe resident transfers quarterly to determine if method and/or devices are safe for resident. Staff is encouraged to try to identify contributing factors at the time of falls; this information is to be included on the initial incident report. Fall team will consider this data when analyzing falls and developing new interventions to prevent/minimize further occurrences. C) Director of Resident Care or designee will educate licensed and unlicensed staff on recording observations at the time of falls. DON will discuss with fall team need to better analyze falls and explore preventive interventions. D) A tool will be implemented to monitor that assistive devices are safe for residents, falls are appropriately analyzed and adequate preventative interventions are in place to prevent further falls. This will be completed monthly and reported quarterly to the PI Committee. DON is responsible for compliance.	

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F 323	Continued From page 14	F 323		

open and close his/her hands but had a very weak grip. Further, the therapist noted the resident fatigued easily. The following concerns were identified:

a. Observation on 11/3/14 at 4:25 PM showed the resident sitting in a wheelchair located in his/her room. The resident indicated pain in both legs. At 4:30 PM, that same day, CNA #1 transferred the resident from the wheelchair located next to the bed to the bathroom using a sit-to-stand lift. Prior to standing the resident, the CNA instructed the resident to support his/her weight on the right leg only during the transfer. The CNA provided incontinence care while the resident was in the lift supported primarily by the sling. After completing the care, the resident was transported in the lift to the bed located furthest from the bathroom. Prior to the resident being placed in bed the CNA needed to reposition the wheelchair which extended the time the resident was up in the sling.

b. During an interview with the DON on 11/6/14 at 11:45 AM, she acknowledged the use of the sit-to-stand lift needed to be re-evaluated for patient safety.

2. Review of the quarterly MDS assessment dated 10/19/14 revealed resident #9 had diagnoses that included hypertension, diabetes mellitus, depression and cerebral vascular accident and was moderately cognitively impaired. The MDS assessment also showed the resident required extensive assistance with dressing, personal hygiene and bathing. Review of a fall review document showed a nursing team discussed the details of the falls which occurred on the following dates: 1/23/14, 6/25/14, 7/31/14, 8/9/14, 9/7/14, 9/15/14, and 10/23/14. The following concerns were identified with developing

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meaningful interventions for the prevention of future falls:

a. The note for the fall on 1/23/14 showed the resident had fallen in his/her room and stated s/he had 'tripped over my own feet.' There was no further analysis of the fall, and the plan was to have the resident call for assistance when getting up.

b. The note for the fall on 6/25/14 failed to show the analysis of how the fall occurred and consisted of assessing the resident for new shoes. There was no documentation in the medical record to show new shoes were evaluated or implemented.

c. The 7/31/14 fall note showed the resident tripped on his/her shoe and fell while in his/her room. The plan was "advised resident to use walker even when in room."

d. The 9/7/14, and the 9/15/14 fall notes showed the resident was again in his/her room and fell during ambulating and transferring. The plan was "reminded to use walker appropriately and ring for assistance" and "asked resident to call for assistance in early morning."

e. The fall notes showed the falls on 8/9/14, and 10/23/14 lacked analysis and additional/new interventions to prevent/minimize future falls.

3. Review of the quarterly MDS assessment dated 8/17/14 revealed resident #35 had diagnoses that included anxiety, depression, End Stage Renal Disease, non-Alzheimer's dementia, heart failure, and morbid obesity; had an indwelling catheter; and was severely cognitively impaired. Further review revealed the resident needed extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Review of a fall review document showed a nursing team discussed the details of

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the falls which occurred on the following dates: 1/2/14, 1/9/14, 3/23/14, 7/15/14, 7/16/14, 8/1/14, 8/6/14, 8/26/14 and 10/31/14. The following concerns were identified with developing meaningful interventions for the prevention of future falls:

a. The note for the fall on 1/2/14 showed a discussion of what occurred (the resident rolled out of bed), but there was no further analysis of the fall.

b. The note for the fall on 1/9/14 showed the resident again rolled out of bed, and "TAP (turn and position) system wedges will be placed to attempt to keep [resident] in bed." There lacked an analysis of the fall.

c. The note for the falls on 7/15/14 and 7/16/14 showed no analysis of the falls and no new interventions to prevent future occurrences.

d. The note for the falls on 8/1/14 and 8/6/14 showed the resident again had rolled out of bed. According to the notes, there was no further analysis of the falls, and no new interventions to prevent future occurrences.

e. The note for the falls on 8/26/14 and 10/31/14 again showed a discussion of what happened, but lacked further analysis of the falls, and no new interventions to prevent future occurrences.

4. Interview on 11/6/14 at 11 AM with the DON, MDS coordinator and the two nurse team leaders revealed they met weekly to discuss falls in the facility. The DON verified there were not always new interventions developed after each fall. She stated it was difficult to generate new ideas, and the interventions that were already in place were often continued.

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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 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 2 of 10 sample residents (#18, #34). The findings were: 1. Review of the medical record showed resident #34 was admitted on 10/31/13 and at that time the physician ordered the anti-depressant	F 329	AHCC will ensure that each resident's drug regimen is free from unnecessary drugs. This will be accomplished by: A) Resident #34 and #18 physician completed a medication review that acknowledged resident specific behaviors/benefits and clinically justified the use of the medication for each of these residents. B) Monthly the Director of Resident Care (DRC) and pharmacist will review all resident records to ensure that a diagnosis correlates with each medication prescribed and that each medication review is resident specific and acknowledges behaviors/benefits when clinical justification for use of a drug is warranted. Any discrepancies will be addressed with the resident's primary physician. C) In service training will be provided to nursing staff regarding medical diagnosis correlating with medication prescribed, and that medication reviews performed are resident specific, and acknowledge resident behaviors/benefits when clinical justification for use of a drug is warranted. D) A Performance Improvement Tool will be implemented by the DRC and pharmacist to ensure that each resident's drug regimen is free of unnecessary drugs. This will be completed monthly and reported quarterly to the PI Committee.	12/20/2014

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medication Zolft 50 milliligrams (mg) daily to treat the resident's diagnosis of depression and dementia. Review of the 2/11/4, 5/13/14, and 8/12/14 quarterly evaluations for the Zoloft showed the behavioral symptoms identified for the use of the medication was "crying/worried exp. [expression], grabbing clothes/resists." The 2/11/14 evaluation failed to show the number of episodes per month when the behaviors occurred. The other two evaluations both showed the behaviors of "grabbing clothes/resists" occurred daily. There were no episodes shown of the behavior of crying and worried expression for any of the quarterly evaluations. Review of the physician progress notes showed the physician continued with the same dose of the medication, until 10/16/14 when the physician signed and dated a pre-typed statement for contraindication of dose reduction and or discontinuation. The diagnosis written in on the pre-typed statement was for dementia and depression. The typed statement was as follows: "The benefits from this medication have enhanced the resident's quality of life and outweigh any potential side-effects, therefore it is contraindicated to change the medication dose or discontinue at this time." The signed statement failed to include clinical justification that was resident specific. There was no discussion of the resident's specified behaviors, or specific benefits the resident was experiencing related to the continued use of the medication. Interview with RN #1 on 11/5/14 at 3:30 PM verified there had not been an attempt to decrease the dose of the medication.

2. Review of the medical record for resident #18 showed s/he was admitted to the facility on 7/30/13. Diagnoses included dementia. Review of the physician's orders dated 10/1/14 through

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F 329	Continued From page 19 10/31/14 showed the resident was prescribed the antidepressant Prozac 20 mg to be administered daily ordered on 7/30/13. Review of the drug regimen review showed on 8/14/13, the pharmacist noted the Prozac did not include a diagnoses for its use and needed to be scheduled for a review of the medication's necessity, benefits and risks. Review of the physician progress notes dated 11/19/13, 3/6/14 and 7/24/14 showed the following preprinted statement; "The benefits from this medication have enhanced the Resident's quality of life and outweigh any potential side-effects, therefore it is contraindicated to change the medication dose or discontinue at this time." Further, the diagnosis indicated for its use was "dementia." There was no additional justification for its continued use specific to the resident. Further, there was no documentation of a medication review. Interview with RN #1 on 11/5/14 at 5:45 PM revealed there was no additional documentation to show further justification for the use of the medication Prozac. In addition, the facility was not aware the generic statement signed by the physician was inadequate.	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356	AHCC will post the following information on a daily basis: Facility name, current date, total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses,Licensed Practical Nurse or Licensed Vocation Nurse (as defined under State law), Certified nurse aides and the Residents census by: A) The AHCC Director of Nursing (DON) or	12/20/2014

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F 356	Continued From page 20 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the posted daily nurse information sheets and staff interview, the facility failed to ensure the hours worked by the nursing staff were clearly indicated. Further, the daily postings did not consistently include the resident census. The findings were: Review of the daily nursing staff information sheet on 11/6/14 at 9:45 AM showed a list of staff names to include the shift they were assigned and the full time equivalents. It did not clearly show the total hours worked during each shift by the individual nursing discipline; RNs, LPNs and	F 356	Continued From page 20 designee will develop a form to be posted for the public to clearly indicate hours worked by the nursing staff and the resident census. B) AHCC Supervisors will complete the form to reflect current staffing, updating as necessary to reflect changes. C) The DON or designee will educate the nursing staff on the information required to be posted in a clear and readable format. The DON or designee will review the nursing staff data weekly; inaccuracies and/or omissions will be addressed with the Supervisors. D) The DON will implement a tool to monitor that correct staffing and census information is posted for the public. This will be completed monthly and submitted quarterly to the PI Committee.	

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F 356	Continued From page 21 CNAs. Further, the daily postings did not always include the resident census. During an interview with the DON at the time of the review, she acknowledged the census needed to be included on all the daily postings and the number of hours worked by each discipline needed to be more clearly defined.	F 356		
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, review of diet order information, and policy and procedure review, the facility failed to ensure 3 of 10 sample residents (#2, #18, #34) and 16 non-sample residents (#8, #11, #12, #13, #15, #16, #17, #20, #21, #23, #26, #27, #29, #33, #36, #41) were served therapeutic diets as planned to meet their nutritional needs. The findings were: 1. Review of the resident diet information sheet dated 11/5/14 showed 18 residents (#2, #8, #11, #12, #13, #15, #16, #17, #18, #20, #23, #26, #27, #29, #33, #34, #36, #41) who required a fortified diet. Fortification is a way to achieve higher calories and protein without greatly increasing food volume. The following concerns were identified: a. Observation of the meal service on 11/5/14 at 11:35 AM showed the diet cards for	F 367	Amie Holt Care Center will assure therapeutic diets are prescribed by the attending physician and provided. This will be accomplished by: A) Residents (#2, #11, #12, #13, #15, #16, #17, #18, #20, #21, #23, #26, #27, #29, #33, #34, #36, #41) will receive diets as ordered by their physicians. B) The Dietary Manager (DM), with assistance from the Registered Dietitian (RD), will review and adjust the diet information sheet/tray cards to correspond with the physician's orders of all residents to assure appropriate items, including portion sizes and enhancements are provided. The DM and RD will review and update as needed the current policy and procedure on Diet Fortification. C) The dietary staff will be educated by the DM, with assistance from the RD, by an in-service on regular and therapeutic diets including portion sizes, tray card use, and appropriate fortification techniques with written material provided as needed including our policy and procedure on "Diet Fortification". New employees will be oriented to this process during orientation. The DM or designee will update the diet information sheet/tray cards when new diet orders are received. D) The DM or designee will review the diet (continued on next page)	12/20/2014

Added Res #8 with permission from Brenda Garm DON 12/8/14 12:07pm RQuick

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(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 367	Continued From page 22 residents #34 and #16 included information to provide fortified meals. When each of these resident's meals were served, cook #1 verified none of the food provided to these residents at this meal was fortified. The cook further stated the only foods that were fortified were the hot cereal in the mornings, and the pureed food items at each meal. b. Interview with the dietary manager on 11/5/14 at 11:50 AM revealed there was not a written plan for meal fortification. She then stated if the resident did not have hot cereal in the morning, or have a pureed texture diet, they did not receive the calorie or protein fortification in their foods. c. Interview with the registered dietitian on 11/6/14 at 12:20 PM revealed a policy and procedure was available and should be followed to ensure the meal fortification was provided. Review of the policy and procedure titled "Diet Fortification" showed it was reviewed on 1/29/14. The information included indications for when to use a fortified diet, and food preparation recommendations for additions to various foods. These additions included more than hot cereal and pureed textured diets. 2. Review of the resident diet information sheet dated 11/5/14 showed resident #21 was to have a limited concentrated carbohydrate diet with small portions and a regular protein portion. Review of the 9/30/14 physician orders showed the resident had a "Regular: LCC (No substitute sweeteners)" diet order. The portions were not otherwise addressed by the physician. Observation on 11/5/14 at 12:15 PM showed the resident was upset at not having received the regular sized portion of chicken. Review of the planned menu showed "stuffed chicken thigh" was the protein in	F 367	Continued From page 22 information sheet/tray cards corresponding to the physician's orders of all residents monthly x3 months then quarterly. This will be presented and reviewed at the facility QAPI meeting to help identify trends and need for further education or monitoring. The DM or designee will monitor 10 trays a week x3 months then 10 trays monthly and report on tray accuracy, including diet fortification appropriateness. This will be presented and reviewed at the facility QAPI meeting to help identify trends and need for further education or monitoring.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	53A002	A. BUILDING _____ B. WING _____	11/07/2014

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F 367	Continued From page 23 the meal and 6 ounces was the planned regular size portion. Observation of the noon meal service at 11:35 AM showed the 6 ounces was severed by providing two pieces of the chicken. Observation of the resident's chicken portion showed 1 piece of the chicken was served. Interview with the DON on 11/5/14 at 5 PM stated the resident had brought this issue up on 10/31/14 and she had talked with the dietary manager on that day. The DON verified the resident was to get the regular portion size for protein and she thought the issue had been corrected.	F 367		
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, 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	F 441	The facility will ensure that infection control procedures are followed and maintained. This will be accomplished by: A) The certified nurse aide who failed to follow appropriate infection control practices while providing personal care to resident #18 and #23 was given one-to-one in service training specifying that gloves need to be removed and hands cleansed following incontinence care. The Infection Control Nurse or designee will observe personal cares for these residents and provide immediate in-servicing if glove use or hand hygiene is inappropriate. B) Infection Control Nurse or designee will randomly observe 6 residents receiving personal cares per month, providing immediate in-servicing if glove use or hand hygiene is inappropriate. C) In service training will be given to nurses and CNAs regarding appropriate infection control	12/20/2014

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F 441	Continued From page 24 (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, staff interview, and review of the facility's policies and procedures, the facility failed to ensure infection control procedures were maintained during 1 random observation which affected residents #18 and #23. The findings were: 1. Observation on 11/3/14 at 4:30 PM showed CNA #1 cleansed her hands then donned 2 pairs of gloves prior to providing incontinence care for resident #18. After completing the care the CNA removed 1 pair of the gloves and did not cleanse her hands. She then transferred the resident to the bed using a sit-to-stand lift and removed the sling used to support the resident while she was in the lift. The CNA continued to provide care to include adjusting linens and putting on the	F 441	Continued From page 24 practices for glove use and hand hygiene following perineal care. The guidelines utilized for CNA testing and accepted by the Wyoming State Board of Nursing will be considered Best Practices for this training and used to update the Amie Holt Care Center policy on perineal care. Upon completion of perineal care the caregiver may reposition resident (for comfort, safety and dignity), dispose of used equipment and linens, then remove gloves and wash hands. D) An infection control monitor regarding glove use and hand hygiene practices following perineal care will be developed. This will be completed monthly and reported quarterly to the Performance Improvement Committee. The Infection Control Nurse will be responsible for compliance.	

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F 441	Continued From page 25 resident's pressure relieving boots. The CNA removed the second pair of gloves and then washed her hands. Review of the the policy and procedure for hand hygiene, last revised on 3/13, showed; "Handwashing or use of an alcohol-based hand rub should be used: e. Before and after procedures, especially when removing gloves". During an interview with the infection control nurse on 11/6/14 at 10 AM, she acknowledged the gloves needed to be removed and hands cleansed following incontinence care.	F 441		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails were securely fastened and maintained on 3 of 3 hallways (100, 200, and 300) used by residents. The findings were: Observation on 11/6/14 at 8:15 AM revealed 10 places on the handrails in the 200 hallway that were loose from the wall or had gaps in the materials that presented abrupt edges. Further observation at that time showed similar conditions in both the 300 (10 handrails that were loose and/or had gaps) and the 100 (8 handrails that	F 468	The facility will ensure that corridors are equipped with firmly secured handrails by: A) Maintenance personnel secured loose handrails with wall anchors, tightened gaps, and filled gaps that could not be completely tightened with silicone. B) Housekeeping personnel cleans handrails daily. When they find gaps or loose areas they will alert maintenance. Once a month housekeeping will complete a checklist on the condition of the handrails. C) The maintenance supervisor and the housekeeping supervisor will in-service their departments on the plan of correction. D) A performance improvement tool will be developed and implemented by the housekeeping supervisor to ensure handrails remain in good repair. This will be completed monthly and reported quarterly to the PI committee.	12/20/2014

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F 468	Continued From page 26 were loose and/or had gaps) hallways. Interview with the maintenance director on 11/6/14 at 9:15 AM revealed he was unaware of the loose handrails and gaps. He further stated the handrails were to be cleaned and checked by the housekeepers, and was unsure about why the handrails were not reported as loose or having gaps. He further confirmed the handrails identified presented a potential safety hazard to the residents.	F 468		

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