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

PRINTED: 06/05/2015
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
	535027	A. BUILDING _____ B. WING _____	C 05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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: BIMS - Brief Interview for Mental Status CNA - Certified Nurse Aide DON - Director of Nursing e-MAR - electronic Medication Administration Record LPN - Licensed Practical Nurse LTCC - Long Term Care Center MDS - Minimum Data Set PRN - Pro re Nata (as needed) RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of activity logs, and resident and staff interview, the facility failed to implement a program of activities designed to meet the needs of 1 of 1 sample resident (#11) on isolation precautions. The findings were: 1. Review of the 5/8/15 admission MDS	F 248	The facility will continue to provide an ongoing program designed to meet the interests of each resident, including those residents on isolation precautions. 1. Resident #11 is no longer on isolation precautions and is participating in congregate meals and activities of his choosing outside of his room. Resident #11's activity participation will be documented in the medical record and reflected on the care plan, including provision of one on one activities in accordance with the resident's individual interests.	7/03/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Kaiser, NHA | TITLE: Administrator | (X6) DATE: 6/15/2015

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.

Re-submitted 7/3/2015

7/27/15 - PoC accepted. Voice mail left for Jeanne Kaiser, administrator. DOC is 7/3/15. J. VanDyke, RN

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F 248	Continued From page 1 assessment showed resident #11 had moderately impaired vision, described in the Resident Assessment Manual as "limited vision; not able to see newspaper headlines but able to identify objects." Review of a progress note dated 5/5/15, timed 7:47 PM, showed the resident was paraplegic, blind from macular degeneration, and had a long history of back pain. Review of an activity assessment dated 4/23/15 revealed the resident was not interested in attending activities at that time. Further review showed activities staff would "continue to visit, invite and encourage [him/her] to join in. We visit together in [his/her] room, offer reading materials and share stories..." Review of the resident's care plan revealed no personalized plan for activities. Additionally, review of the care plan showed the resident had tested positive for Clostridium difficile on 5/15/15 and was placed on contact precautions. The following concerns were identified: a. Interview on 5/19/15 at 12:30 PM with resident #11 revealed the resident was "anxious," "climbing the walls," unsure if s/he would be able to handle his/her paraplegia, and was having nightmares. The resident stated that, due to macular degeneration, s/he could not watch television or read, and "I don't have anything to do. I get lonesome when I don't have anyone to talk to and after I've been lonesome for about an hour I start really hurting." The resident also stated s/he had been going to the main dining room for meals, but since being put on contact precautions had to stay in his/her room for meals, and "no one wants to come in here." b. Review of the 5/8/15 admission MDS assessment showed the resident rated the following activities as very important: having books, newspapers and magazines to read, keeping up with the news, doing things with	F 248	2. All residents whose activity participation is limited due to confinement to their room have been assessed to determine an individually appropriate activity plan agreeable to the resident. The activity plan has been documented on the residents' medical record and plan on care. 3. All residents will be assessed upon admission and upon any significant change affecting their ability to participate in activities, to determine the residents' individual interests and develop an activity plan to meet those interests. The results of the activity assessment and activity participation are documented in the residents' medical record and the care plan. 4. A Quality Improvement/Performance Improvement (QI/PI) indicator has been developed to monitor the development, implementation, and documentation of individualized activities for each resident, and the results are reported to the facility's QI/PI Committee on a quarterly basis. 5. The Activities Coordinator is responsible for and the Administrator monitors the provision and appropriate documentation of individualized activities.	

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F 248	Continued From page 2 groups of people, doing favorite activities, and going outside to get fresh air when the weather is good. c. Interview with the activities director on 5/21/15 at 1:50 PM revealed no special activity program had been put in place for the resident since s/he had been put on contact precautions. The activity director further stated activities staff visited with the resident one on one, but they did not read to him/her. d. The activities department was unable to provide complete activity logs, however, review of logs provided for 5/11/15, 5/12/15, 5/13/15, and 5/19/15 showed that, while one to one visits were being made with residents in the facility, resident #11 was not one of the residents receiving one to one visits.	F 248		
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 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	F 279	The facility will continue to ensure that care plans are individualized for all care areas, including mood, psychosocial needs and behaviors. 1. Resident #45 discharged on 6/03/2015 to another facility closer to his home. 2. Resident #72 was re-assessed for activity interests, and for mood, psychosocial needs and behaviors, and an individualized plan of care was developed and documented to meet those interests and needs, including use of non-pharmacological methods to be used as an alternative to medications for mood and depression.	7/03/2015

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F 279	Continued From page 3 §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, observation, and resident and staff interviews, the facility failed to ensure care plans were individualized for areas related to mood, psychosocial needs and behaviors for 2 of 13 sample residents (#45, #72). The findings were: 1. Review of the comprehensive MDS assessment dated 5/7/15 showed resident #45 was admitted to the facility on 4/24/15 with diagnoses that included Alzheimer's Disease and depression. The assessment completed for mood demonstrated moderate depression. Review of preferences for activities showed the resident indicated reading materials and music were very important to him/her. Further, favorite activities and being outside during good weather was somewhat important. Review of the medication list showed the resident was prescribed the anti-psychotic medication Seroquel 12.5 mg (milligrams) 2 times daily PRN and the anti-depressant Paxil. Review of the care plan for mood, behaviors and psychosocial only showed the resident would participate in scheduled mood assessments at a minimum of quarterly. It did not include the resident's activity preferences or other non-pharmacological methods to be used as an alternative to medications for mood and depression. 2. Review of the comprehensive MDS assessment dated 10/7/14 showed resident #72 was admitted to the facility on 9/24/14 with	F 279	3. All residents identified as having mood, psychosocial needs and/or behaviors have had their monitoring process revised to include non-pharmacological alternatives, including activities, to the use of medication prior to the administration of as-needed (PRN) medication. The residents' plan of care have been updated to reflect these alternative methods. 4. Staff education was conducted to inform employees on the utilization of the revised monitoring process and the requirement for the use of non-pharmacological methods prior to administration of PRN medication to address mood, psychosocial needs and/or behavior. 5. A QI/PI indicator has been developed to monitor the use of non-pharmacological methods and its inclusion on the residents' care plans, and reported to the facility's QI/PI Committee on a quarterly basis. 6. The Director of Nursing is monitoring.	

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F 279	Continued From page 4 diagnoses that included depression. In addition, it showed preferences for activities included music, reading materials, groups of people, animals/pets and religious practices. Review of the medication list showed the resident was prescribed the anti-anxiety medication Ativan routinely and as needed every 6 hours, the anti-psychotic Seroquel, and the anti-depressant Zoloft. Review of the e-MAR for the prescribed PRN medication Ativan showed the resident received it 15 times between 5/2/15 and 5/19/15. Review of the care plan for mood, behaviors and psychosocial only showed the resident would participate in scheduled mood assessments at a minimum of quarterly. It did not include the resident's activity preferences or other non-pharmacological methods to be used as an alternative to medications for mood and depression.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff and resident interviews and review of the facility's policies and procedures, the facility failed to ensure residents were appropriately assessed for pain for 1 of 11 sample residents (#62) receiving PRN pain medications. In addition, the	F 309	The facility will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, including appropriate assessment and treatment for pain and wound care. 1. The medication regimen of resident #62 was reviewed and revised by the physician on 6/01/2015 to more adequately address his pain management needs. This resident's care plan was revised to include specific information regarding assessment, management and treatment for pain.	7/03/2015

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F 309	Continued From page 5 facility failed to complete wound assessments for 1 of 1 sample resident (#31) with wounds. The findings were: 1. Review of the comprehensive MDS assessment dated 1/2/15 showed resident #62 had diagnoses that included hip fracture and depression. Review of the assessment for pain showed the resident indicated s/he had pain almost constantly that limited daily activities. The pain was described as severe. Review of the quarterly MDS assessment dated 4/3/15 showed the patient continued to have frequent pain that limited his/her activities. Review of the medication list showed the resident was prescribed the pain medications acetaminophen 1000 mg (milligram) every 8 hours PRN ordered 1/17/15, and Norco 5/325 mg every 4 hours PRN ordered 1/29/15. The following concerns were identified: a. Review of the e-MAR for Norco showed the resident received Norco 15 times between 5/16/15 and 5/20/15. Pain assessments prior to the administration of the medication were not completed 6 times (40%). Review of documented pain assessments completed failed to consistently show the level of pain prior to the administration of pain medication. For example: review of the pain documentation on 5/20/15 at 10:33 AM showed the pre-administration assessment indicated the resident had generalized pain. There was no further documentation to show the level of pain the resident had. The post administration pain assessment, timed 11:01 AM, showed the resident had continued generalized pain and for Pain Scale Used it showed "Comfort (grimacing)." b. Review of the e-MAR for acetaminophen showed the resident received the medication 15 times between 2/10/15 and 4/26/15. Pain	F 309	2. Residents who are identified as having pain management needs have this need and individualized interventions reflected on their care plan. 3. Education has been provided to further inform staff regarding appropriate pain management assessment, treatment, and documentation, including non-pharmacological techniques for treatment of pain. 4. Resident #31 has a chronic skin condition which periodically recurs. An intervention for a head-to- toe skin assessment for Resident #31 has been implemented for a licensed nurse to complete on a weekly basis. Information from this assessment has been added to the resident's care plan. 5. The wound care assessment completed by the wound care nurses has been modified to include a notification to the facility wound care team regarding new or changed wound care issues which require intervention, monitoring and/or follow-up. 6. Education has been provided to further inform staff of wound care assessment protocols, including the need for measurement of any wound at time of first identification.	

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F 309	Continued From page 6 assessments were not completed prior to its administration 11 times (73%). Review of the documented pain assessments failed to clearly indicate the effectiveness of the medication. For example, the nurse indicated the resident had complained of severe pain on 4/18/15 at 9:50 PM and was given acetaminophen at that time. The location of the pain was not indicated The post pain assessment, timed 10:20 PM, showed the following behaviors were observed: moaning, guarding, restlessness, facial grimacing, relaxed, happy. It was unclear if the pain medication was effective. c. Review of the care plan for pain dated 4/2/15 only showed the resident was to be given Tylenol (acetaminophen) or Norco for pain. There were no non-pharmacological interventions indicated. Further, the care plan did not indicate which of the pain medications was to be administered for what level of pain. d. Review of the policy and procedures entitled: "Pain Management," last revised April 2005, showed "...5. Record pain intensity and response to interventions on the MAR- Pain Assessment sheet..." Further, it showed non-invasive techniques for controlling pain included cold therapy, distraction, position changes and relaxation techniques. e. During an interview with the DON on 5/21/15 at 12:55 PM, she acknowledged pre- and post-assessments needed to be completed each time a pain medication was administered. 2. Review of the 2/17/15 quarterly MDS assessment showed resident #31 had diagnoses that included heart failure, diabetes mellitus, seizures, and schizophrenia. Further, the resident needed extensive assistance with bathing. Review of the nursing notes showed the resident	F 309	7. A QI/PI indicator has been developed to monitor appropriate assessment, management and documentation of pain and wound issues. The results of this monitoring are reported to the facility's QI/PI Committee on a quarterly basis. 8. The Director of Nursing is monitoring.	

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F 309	Continued From page 7 had a skin issue that was described on 4/12/15 as a "boil-like area". Review of the wound assessment note dated 4/18/15, timed at 11:54 AM, showed "noted area on R [right] breast that looks better than 2 days ago, today flat, soft, somewhat fluctuant, somewhat tender to palpation. Does not appear infected at this time or in need of any surgical lancing. Will monitor for changes. No real change since seen on Thursday." Review of the quarterly review dated 5/18/15 timed at 10:32 AM showed "4/12/15 a raised red area on the right breast found. Referred to wound care RN team, and they watched it, but it resolved without treatment." The following concerns were identified: a. Interview with the resident on 5/21/15 at 10:30 AM revealed the area was still present and hurting. Observation on 5/21/15 at 10:50 AM with the resident and the DON revealed the area was still red, raised and circular in nature. b. Interview with the DON on 5/21/15 at 12 PM confirmed no further skin assessments were available between 4/18/15 and 5/18/15. c. Review of the wound assessment dated 5/21/15 timed at 2:30 PM showed "area to breast has small open area...site looks like it had drained and the tissue to the abdomen under the breast and around the open area is red and irritated most likely due to the draining," however, the assessment was lacking wound measurements.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	The facility will continue to provide a safe environment for all residents. 1. Resident #45 discharged on 6/03/2015 to a facility closer to his home.	7/3/2015

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F 323	Continued From page 8 prevent accidents. 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 provide a safe environment in 1 of 1 activity areas. In addition, the facility failed to analyze elopement incidents to determine possible system failures for 1 of 1 sample residents (#45) reviewed for elopement. The findings were: 1. Observation on 5/21/15 at 10 AM of the activity room, located in an open area on the main level, revealed the stove used for cooking and baking could be turned on for use. State Survey Agency staff turned the controls for the stove to the on position and the burners immediately heated up. Further observation showed scissors used for cutting fabric and cardboard were left out in the open. During this observation were no staff available to supervise the area and the area was open for resident use. During an interview with the activities director on 5/21/15 at 10:25 AM, she revealed the stove and oven had a locking mechanism that rendered the appliance inoperable. The director verified it needed to be locked when it was not in use and/or unsupervised. Further, she acknowledged sharp instruments needed to be secured when the area was not supervised by staff for resident safety. 2. Review of the physician history and physical report dated 4/21/15 showed resident #45 was brought to the emergency room (ER) after being	F 323	2. The tool used to evaluate individuals referred for facility admission has been revised to further assess elopement risk. If this evaluation indicates an elopement risk that cannot be safely managed by the facility, admission will be declined. 3. Upon admission, all residents are further assessed for safety factors including risk for elopement, and appropriate interventions developed, which will be reflected on the residents' care plan 4. All current residents who have already been identified as at risk for elopement have been evaluated to ensure that adequate interventions have already been developed to prevent elopement. Any needed changes in interventions are reflected on the residents' care plan. 5. Education has been provided to staff regarding elopement risk assessment, interventions, and the policy and procedure for Locating a Missing Resident. Review of this policy is also included in the department-specific orientation provided to all newly hired employees.	

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F 323	Continued From page 9 found wandering several blocks from his/her home. At the time of the ER admission, the resident was confused and complaining of chest pain. Review of the comprehensive MDS assessment dated 5/7/15 showed the resident was admitted to the long term care facility on 4/24/15. Diagnoses included coronary artery disease, depression and Alzheimer's disease. Review of the Nurse/Physician Communication dated 5/5/15 showed the resident had successfully eloped from the long term care center at 2 AM. The document further showed the resident had a wanderguard device on at the time and was eventually found outside approximately one hour later. Review of the report summarizing the incident dated 5/5/15 showed the following: a. At approximately 2 AM, a door alarm sounded at the nurses station. An investigation ensued, the resident's wheelchair was found near the exit with the door alarm sounding. The surrounding areas and rooms located on the east unit, where the resident resided, were searched. b. At 2:30 AM the emergency medical service crew leader and house supervisor were notified. Assistance was requested to help locate the missing resident. c. At 2:50 AM the resident was located outside of the facility at the north end of the employee parking lot. The resident was lying down on a rocky area. The resident was then taken to the ER for evaluation. Continued review of documentation related to the incident did not show an evaluation was completed to determine how the resident was able to exit the facility and to analyze the length of time it took to locate the resident. In addition, there was no evidence an analyses of the incident was completed to evaluate where the system	F 323	6. A QI/PI indicator has been developed to monitor the completion of risk elopement assessments for newly admitted residents, and the appropriateness of interventions developed for all residents determined to be at high risk for elopement. The results of this monitoring are reported to the facility's QI/PI Committee on a quarterly basis. 7. A QI/PI indicator has been developed to monitor the *provision* of staff education regarding elopement risk, and knowledge of the policy and procedure for locating a missing resident. The results of this monitoring will be reported to the facility's QI/PI Committee on a quarterly basis. 8. The locking mechanism for the stove in the activity kitchen on the main level was activated on 5/21/2015, and the scissors found in the activity area were removed to a safe location on 5/21/2015. 9. The activity area is being supervised and inspected frequently throughout the day by activities staff and administration to ensure the locking mechanism for the stove is activated and that sharp instruments are secured when the area is unsupervised.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 06/21/2015

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WEST PARK LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 323	Continued From page 10 failed in order to prevent any future elopements. Review of the list of residents with wanderguards provided by the facility showed there were currently 3 additional residents with wanderguards residing on the east unit of the main floor, the same unit resident #45 eloped from. Review of the policy and procedure entitled "Locating a Missing Resident" last revised 8/10 showed; "If for any reason the resident cannot be located, the following procedure shall be initiated by the charge nurse: "6) If the resident has not been located within 5 minutes...After 4:30 PM, PageGate the on-call Plant Operations staff member STAT, and telephone the Security Guard..." The policy showed the plant operations staff was to assist with a building and grounds search. "7) If the resident cannot be located within 10 minutes: ...The charge nurse or on-call LTCC Supervisor shall telephone the police department..." There was no documentation to show the plant operations staff and police were notified of the elopement. During an interview with the DON on 5/21/15 at 12:55 PM she revealed the facility did not have doors that locked down if a resident with a wanderguard attempted to exit the building. The resident only needed to push the bar latching the door for 15 seconds and the door would open. She acknowledged the current system was not adequate for keeping wandering residents from eloping.	F 323	10. A Quality Improvement/Performance Improvement (QI/PI) indicator has been developed to monitor the provision of a safe environment, and the results reported to the facility's QI/PI Committee on a quarterly basis. 11. The Activities Coordinator is responsible for maintaining a safe environment in the Activities areas. 12. The Administrator is monitoring.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329	The facility will continue to ensure that residents' medication regimens are free from unnecessary drugs.	7/03/2015

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F 329	Continued From page 11 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, staff interview and review of policies and procedures, the facility failed to ensure a comprehensive assessment was completed for 2 of 4 sample residents (#45, #72) receiving PRN psychoactive medications. The findings were: 1. Review of the comprehensive MDS assessment dated 5/7/15 for resident #45 showed the resident was admitted to the facility on 4/24/15 with diagnoses that included Alzheimer's Disease and depression. Further it	F 329	1. Resident #45 discharged on 6/03/2015 to another facility closer to his home. 2. The medication regimen of Resident #72 was reviewed by the Medication Review Team, which includes the facility Medical Director, a registered pharmacist, the Director of Nursing, the Social Worker, and other members of nursing and administration. Following this review, a recommendation was made to the resident's primary care physician regarding potential dose reductions for this resident's psychoactive medications. 3. Non pharmacological interventions have been developed for Resident #72 and all other residents on psychoactive medications for use as alternatives to medications for those residents. The non-pharmacological alternatives are reflected on the residents' care plan. 4. All residents on psychoactive medications are reviewed by the Medication Review Team, and recommendations for possible dose reductions and/or discontinuation of psychoactive medications are provided to the residents' primary care physician.	

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F 329	Continued From page 12 showed the resident had a BIMS score of 9/15 indicating moderate cognitive impairment. The assessment completed for mood demonstrated moderate depression. Review of preferences for activities showed the resident indicated reading materials and music were very important to him/her. Further, favorite activities and being outside during good weather were somewhat important. Review of the medication list showed the resident was prescribed the antipsychotic medication Seroquel 12.5 mg (milligrams) 2 times daily PRN ordered on 5/5/15. The following concerns were identified: a. Review of the sleep assessment dated 4/27/15 showed the resident was prescribed Ambien (a sleep aid) prior to his/her admission to the facility. The resident indicated s/he occasionally woke up with a headache and was afraid of going to sleep at night. Continued review of the assessment showed nursing recommendations included a trial of additional hypnotics and/or sleep inducers. Further, it showed the resident demonstrated signs and symptoms of anxiety. There was no documentation to indicate there was a discussion concerning possible non-pharmacological interventions. b. Review of the case management note dated 5/5/15 showed the physician was consulted. The medications Ambien and Effexor (anti-depressant) were discontinued and melatonin (used in part for insomnia), Paxil (antidepressant) and Seroquel (anti-psychotic) were initiated. Further, it showed the resident was to be monitored. There were no additional interventions recommended or discussed. c. Review of the e-MAR showed the resident received the PRN medication Seroquel 9 times between 5/5/15 and 5/21/15. Further, it showed	F 329	5. Education has been provided to staff regarding the need to attempt to use non-pharmacological alternatives prior to administering a psychoactive medication, and regarding use of appropriate diagnoses and required documentation of observation of behaviors or other indications prior to administering a psychoactive medication. 6. A QI/PI indicator has been developed to monitor the use of non-pharmacological alternatives prior to the administration of psychoactive medications; and to monitor the appropriate diagnoses and documentation of indicators for use prior to psychoactive medication administration. 7. The results of this monitoring are reported to the facility's QI/PI Committee on a quarterly basis. 8. The Director of Nursing is monitoring.	

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F 329	Continued From page 13 an assessment was documented for only 2 of the 9 doses administered. d. Review of the nurse's note dated 5/17/15, timed 8:58 PM, showed the resident had expressed an interest in attending church services but they were not being held at that time. The nurse then documented the resident seemed to "want company." Seroquel and Tylenol were then administered for comfort. Review of the nurse's note dated 5/18/15 timed 5:31 AM, showed the resident was adjusting well to the room change. Further, it showed s/he was given Seroquel to "calm behaviors." The note did not described the resident's behaviors before or after the medication was administered to determine effectiveness. In addition, there was no documentation non-pharmacological interventions were attempted prior to the Seroquel. 2. Review of the comprehensive MDS assessment dated 10/7/14 showed resident #72 was admitted to the facility on 9/24/14 and had diagnoses that included depression and dementia. Further, it showed the resident received anti-psychotic, anti-anxiety and anti-depressant medications. Review of the medication list showed the resident was prescribed Ativan (anti-anxiety) daily and as needed every 6 hours, Seroquel and Zoloft (anti-depressant). Review of the physician clinical note dated 4/21/15 showed the resident reported s/he was doing "great" and was very happy at the long term care facility. The family member stated that the resident's improved state was related to "adjusting to all the changes over the past 6 months." Review of the e-MAR for the prescribed PRN medication Ativan showed the resident received it 15 times between 5/2/15 and 5/19/15. Further review showed assessments were	F 329		

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F 329	Continued From page 14 completed after the medication was given. There was no documentation of behaviors prior to its administration to indicate the reason the Ativan was given. 3. Review of the policy and procedure for "Monitoring Psychoactive Medications" dated 11/12 showed: Antipsychotic drugs will be used with supporting diagnosis and only when they improve functionality of the resident. Attempts will be made to reduce psychoactive medications, when possible. Actions taken to reduce or replace psychoactive mediations will be documented..." 4. During an interview with the DON on 5/21/15 at 12:55 PM, she acknowledged non-pharmacological interventions needed to be attempted. Further, medications should not always be the first intervention for displayed behaviors.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and resident, family and staff interview, the facility failed to provide meal trays to room-bound residents in a time frame that would ensure hot meals for 2 of 2 sample residents (#11, #17) and 3 non-sample residents	F 364	The facility will ensure that residents who are room-bound are provided meals in a time frame that will ensure hot meals. 1. The delivery of meal trays to residents who are room bound, including residents #11, #17, #3, #25, and #27, is being monitored by nursing management and charge nurses to ensure the meals are served at the proper temperature, including resident interviews regarding food satisfaction.	7/03/2015

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F 364	Continued From page 15 (#3, #25, #27) who received room trays. The findings were: 1. Observation on 5/20/15 showed a cart with prepared meal trays was delivered to the East unit at 5:35 PM and parked against a wall. The following concerns were identified: a. Observation showed the first of the trays was delivered to resident #25 at 6:20 PM (45 minutes after the trays arrived on the unit). b. A room tray was delivered to resident #27 at 6:25 PM (50 minutes after the trays arrived on the unit). c. A room tray was delivered to resident #17 at 6:27 PM (52 minutes after the trays arrived on the unit). Interview with the resident at 6:45 PM revealed the food was cold. d. Room trays were delivered to resident #11 and a family member at 6:34 PM (59 minutes after the trays arrived on the unit). Interview with the resident and family member at 6:43 PM revealed the food was "good, but cold" and further revealed their meals were "usually about this temperature." e. A room tray was delivered to resident #3 at 6:41 PM (66 minutes after the trays arrived on the unit). Interview with the resident at 6:47 PM revealed the food was "not that hot." CNA #1, who was providing feeding assistance to the resident at that time, revealed the resident liked his/her food "really hot," however, she had not offered to reheat the meal. f. Review of the policy and procedure entitled, "Meal Service - LTCC" showed "...c. LTCC nursing staff will be responsible for passing meals and beverages to each resident who is on a room tray..." g. Interview with the DON on 5/21/15 at 1:25 PM confirmed meals should be delivered to	F 364	2. Meal trays for residents who are room-bound are now prepared in the facility dining room instead of the distant hospital kitchen to reduce heat loss from transport time. 3. A method has been implemented to assign a specific employee the responsibility of delivering meal trays to rooms to ensure timely meal service for room-bound residents. 4. Education has been provided to staff to ensure awareness of the need for timely room tray delivery for room-bound residents, and explain the method of daily assignment for delivery of room trays. 5. A QI/PI indicator has been developed to ensure that meal trays for room-bound residents are served in a timely manner, to include resident satisfaction with the temperature of meals taken in their rooms. The results of this monitoring are reported to the facility's QI/PI Committee on a quarterly basis. 6. The Director of Nursing is monitoring.	

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F 364	Continued From page 16 residents in a timeframe that keeps the food hot.	F 364		
F 371 SS=E	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 and staff interview, the facility failed to ensure food was stored under sanitary conditions in 1 of 3 walk-in refrigerators. The findings were: Observation on 5/18/15 at 10:25 AM showed ready-to-eat cooked potatoes in a pan, partially uncovered, were stored under raw hamburger in a shallow pan, which was being thawed in the walk-in. Interview with the Executive Chef at that time verified the ready-to-eat foods should be stored away from the raw meat to prevent contamination issues. According to Food Code 2013, U.S. Public Health Service, 3-302.11 "(A) FOOD shall be protected from cross contamination by: (1) Separating raw animal FOODS during storage, preparation,	F 371	The facility will continue to ensure that food is stored under sanitary conditions. 1. The ready-to-eat cooked potatoes were removed from the walk-in refrigerator and disposed of on 5/18/2015. 2. All food storage areas, including the walk-in refrigerators, are inspected on a daily basis by the Certified Dietary Manager (CDM) or designee, to ensure all food is stored under sanitary conditions. 3. Nutrition Services staff was further educated regarding the requirements for proper storage of food to protect from cross contamination as per U.S. Public Health Service Food Code 2013. 4. A QA/PI indicator has been developed to monitor the storage of food, and the results of this monitoring are reported to the facility's QI/PI Committee on a quarterly basis. 5. The Director of Nutrition Services/CDM is monitoring for compliance.	7/03/2015

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F 371	Continued From page 17 holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, and (b) Cooked READY-TO-EAT FOOD;..."	F 371		
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 (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	F 441	The facility will continue to maintain infection control practices designed to prevent the spread of infectious disease. 1. Resident #11 is no longer on contact precautions as of 6/03/2015. 2. Certified Nursing Assistant (CNA) #2 and #3 received one-to-one inservice regarding proper use of personal protective equipment (PPE) including disposable gowns and gloves for residents on contact precautions. 3. All staff received an inservice to further educate them regarding mandatory use of PPE when providing care to any resident on contact precautions.	7/03/2015

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F 441	Continued From page 18 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, review of facility policy and procedure, and staff interview the facility failed to maintain infection control practices designed to prevent the spread of infectious disease for 1 of 1 sample resident (#11) on contact precautions. The findings were: 1. Review of the 5/8/15 admission MDS assessment showed resident #11 was frequently incontinent of bowel, and required extensive assistance with toilet use. Review of the resident's care plan showed s/he was paraplegic, had tested positive for Clostridium difficile infection on 5/15/15, and was put on contact precautions at that time. Observation of the resident's room on 5/18/15 at 8:55 AM showed a sign on the door indicating contact precautions were necessary, and personal protective equipment (PPE) including disposable gowns, gloves, and masks was stored in a cart next to the door. The following concerns were identified: a. Observation on 5/19/15 beginning at 12:44 PM revealed the resident was lying in bed, and had been incontinent of bowel. CNA #2 responded to the call light at 12:45 PM and entered the room without donning a gown. The CNA closed the window blinds, and donned gloves. She then proceeded to assist the resident	F 441	4. At the next occasion when a resident is placed on contact precautions, and in future cases thereafter, nursing management and charge nurses will closely monitor on an ongoing basis the use of appropriate PPE by staff providing care for those residents. 5. The results of this monitoring are reported to the facility's QI/PI Committee on a quarterly basis. 6. The Director of Nursing is monitoring.	

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F 441	Continued From page 19 with turning onto his/her right side (facing away from the CNA). The resident, the resident's clothing, and the bedding were soiled with soft, brown excrement. The CNA performed bowel incontinence care, did a complete bedding change, and changed the resident's clothing without donning a gown. At 12:58 PM, CNA #2 pressed the call light for assistance. CNA #3 entered the room at 1:02 PM without donning a gown, donned gloves, and assisted CNA #2 with repositioning the resident in bed. b. Interview with LPN #2 at 1:07 PM confirmed the resident remained on contact precautions, and the expectation that any staff providing personal care to a resident on contact precautions would don PPE that included a disposable gown. c. Review of the facility policy and procedure entitled, "Multidrug-Resistant Organisms (MDROs) Policy - LTCC" with an initiation date of 1/2012 showed "...Common examples of MDROs include...9. Clostridium difficile..." and "...When a resident is suspected or confirmed to have an infection with an MDRO, the resident is to be placed in Contact Precautions (at a minimum). Upon entering the resident's room, gown and gloves must be worn at a minimum..." d. Interview with the infection preventionist on 5/21/15 at 9:26 AM confirmed the expectation that PPE be utilized when caring for a resident on contact precautions included gown and gloves at a minimum.	F 441		