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

PRINTED: 02/26/2016
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
	535023	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	1124 WASHINGTON BLVD NEWCASTLE, WY 82701

(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 NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency. A recertification survey was conducted by Healthcare Licensing and Surveys on 2/8/16 through 2/11/16.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 1 dining area floor was maintained in a condition that would allow for adequate cleaning. In addition, the facility failed to ensure resident rooms in 4 of 6 resident areas (Hall #1, Hall #2, Hall #3, Hall #5) were maintained in a condition that would allow for adequate cleaning. The findings were:	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior by: 1. Dining room floor tiles will be repaired with appropriate materials to seal in the cracks. The entire floor will be replaced with the construction project in August 2016. 2a. The baseboard in the bathroom and bedroom of room #12 will be repaired. The room will be monitored monthly with safety inspections.	3/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Administrator 3/11/16

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.

WY Dept of Health
MAR 11 2016
Healthcare Licensing and Surveys

spoke with Dawn on 3/11/16 at 11:30am
Plan accepted with date of compliance of 3/25/16 Tim

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F 253	Continued From page 1 1. Observation of the dinning room on 2/8/16 at 2:05 PM and again on 2/11/16 at 9:35 AM showed a crack across the entire floor through various tiles that measured 442 inches across. The crack was darkened with dirt and debris. In addition, there were 7 tiles which measured 12 inches by 12 inches each in the middle of the dining area that were cracked around the edges and raised enough above the adjacent tiles to collect darkened dirt and debris. Also, 6 tiles which measured 12 inches by 12 inches were cracked in various places that were located at the entrance to the dining area and across from the activity room. Those cracks were darkened and created an uncleanable surface. 2. Observation on 2/11/16 from 8:45 AM through 9:25 AM showed the following concerns with resident rooms: a. The bathroom of room #12 had baseboard pulled away from the back wall from the floor to 2 inches up and 18 inches across which exposed wall surface damage. The bedroom of room #12 had baseboard by the closet on the left pulled away from the wall 4 inches up and 6 inches across. b. The floor of room #10 had 10 various cracks with the largest measuring 14 inches across. The cracks were darkened and created an uncleanable surface. c. The wall under the television and to the right in room #3 had wall damage that measured 22 inches up from the floor and exposed metal underneath. d. The wall to the right in room #7 was damaged 3 inches above the floor and 14 inches across which exposed metal. The bathroom of room #7 had damage to the left and back wall with a scrape through the drywall which	F 253	2b. The flooring in room #10 will be replaced. It will be monitored with other flooring issues in monthly safety inspections. 2c. The damage to the wall in room #3 will be patched and painted. It will be monitored with monthly safety inspections. 2d. The areas of the walls listed in room #7 will be corrected by patching and painting. It will then be maintained with monthly monitoring through safety inspections. 2e. Room #8 walls will be patched and painted to fix the corrections listed. Baseboards in this room will also be repaired It will be monitored during monthly safety inspections. 2f. The door frame in the bathroom of room #1 will be painted. Monthly safety inspections will monitor it. 2g. In room #3 the wall to the right of the bathroom will be patched and painted in the damaged area. Safety inspections will be done monthly. 2h. The wall in room #25 will be repaired by patching and painting the area above the baseboard. Monthly safety inspections will monitor it. 2i. The bathroom door in room #21 will be repaired with patching and painting. It will be monitored by monthly safety inspections.	

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F 253	Continued From page 2 measured 5 feet and 5 inches across on the left and 24 inches on the back. e. The back wall in the bathroom of room #8 to the left of the toilet above the baseboard was torn through the wall 11 inches up and 3 inches across. f. The bathroom doorframe of room #1 was scraped and chipped on both sides from the floor to 14 inches up with missing paint and metal exposed. g. The wall to the right in the bathroom of room #3 was scraped into the drywall at 12 inches above the floor and 32 inches across. h. The wall to the right in the bathroom of room #25 just above the baseboard was scraped through the wall 36 inches across. i. The bottom of the inner bathroom door of room #21 was scraped from the left edge to 32 inches across. j. The right wall of room #22 had damage through the drywall at 35 inches above the floor and 14 inches across. Interview with the maintenance director on 2/11/16 at 10:45 AM confirmed he was aware of the damage to the floor in the dining area, and the damage to the floors and walls in resident rooms. However, the facility failed to have a plan with a specific timeframe to address those issues.	F 253	2j. The wall in room #22 will be corrected by patching and painting. Each mouth safety inspections will be performed by the Maintenance Department. 3. Maintenance Director will educate Environmental Services staff on monitoring and reporting issues related to maintenance of resident environment. 4. Identified issues will be reported via the Request Utility and repairs will be scheduled as they are received. 5. Maintenance Department will monitor compliance when completing monthly walk throughs and report to QA monthly.	
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	F 279	F279 The facility will develop a comprehensive care plan for resident #6 and all residents that includes measurable objectives and timetables to meet each resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This will be accomplished by:	3/25/16

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F 279	Continued From page 3 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, incident report review, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 12 sample residents (#6). The findings were: Review of a 10/18/15 incident showed resident #6 had the following documented: "Was notified that a visitor came in and notified us that resident was going down the road in [gender] wheelchair, also received 2 phone calls that [gender] was going down the road in [gender] wheelchair." Review of an 11/11/15 Interdisciplinary Team Care Plan Review showed the following: "[Family member] requests resident be able to drive home per self via power chair. Team suggested a flag be put on power chair. Resident and family stated they had a flag at home." The following issues with the plan of care were identified: a. Review of the entire care plan showed the facility failed to initiate a plan to address the resident leaving the facility in his/her electric	F 279	1. The care plan for resident #6 and all residents who leave the facility independently will include measures to assure resident safety when out of the facility. 2. DON and SW have met with Resident #6 and her family and reviewed a plan for resident to leave the building to visit family. 3. Resident has been instructed to inform staff when she intends to leave the facility to visit family. 4. A wanderguard attached to the motorized conveyance to alert staff when resident is leaving the building was suggested as a double-check system. Resident refused this. 5. DON has created a form to document when resident #6 and all residents leave and return to the facility. 6. A time-line has been established to determine length of time it takes resident #6 to reach destination. Staff will notify family when resident #6 leaves the facility en route to family home. Family will notify facility when resident leaves the home to return to the facility. Similar process will be developed for all residents who leave the facility independently. 7. DON will educate all staff on this process. The process will be used for all residents who leave the facility indenpendently. Social Services will educate all residents on admission. DON	

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F 279	Continued From page 4 wheelchair to determine how staff were to be made aware when the resident leaves, how long the resident would be away from the facility before staff would be required to complete a safety check, and who would be responsible to place the flag on the resident's wheelchair for safety. b. Interview with the administrator on 2/11/16 at 10:10 AM confirmed the facility failed to complete a care plan to address the resident's visits to family in the neighborhood independently via electric wheelchair.	F 279	will attend resident council and educated current residents on the process. 8. DON will monitor compliance weekly and report to QA monthly	
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 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure safety was assessed for 1 of 1 sample residents (#6) who left the facility without supervision. The findings were: 1. Review of the quarterly MDS assessment dated 2/3/16 showed resident #6 had diagnoses that included cerebral palsey and anxiety disorder. Further review showed the resident was cognitively intact with a BIMS score of 15. The resident was determined to be independent with	F 323	F323 The facility will ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: 1. The Therapy Department will perform a safety assessment of driving skills of all residents who have motorized conveyances. 2. DON will perform a risk assessment of routes to be traveled when residents leave the facility independently. 3. Maintenance Department will place a flag and reflective stickers on the motorized conveyance vehicle of resident #6 and all residents who leave the facility via w/c or motorized w/c . 4. DON has created a form to document when resident #6 and all residents leave and return to the facility.	

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F 323	Continued From page 5 locomotion with the use of an electric wheelchair. The following concerns were identified: a. Review of a progress note dated 10/18/15 and timed 2:15 PM showed the resident requested medication so s/he could leave the facility. The nurse asked if the resident's mom was at the facility and the resident stated "not yet she will be coming I just called her." As the nurse walked to the nurse's station a visitor told the nurse that resident #6 was "at the intersection in [his/her] wheelchair. The nurse went outside at that time and was unable to see the resident. Upon return to the nurse's station, a different nurse was on the phone with another individual reporting the resident was "out on the road in [his/her] wheelchair." b. Review of a progress note dated 10/18/15 and timed 2:36 PM showed the facility "received 2 phone calls and 1 visitor came and notified that the resident was going down the road in [his/her] wheelchair." Further, the nurse called the resident's mother and told her "for safety reasons we cannot have residents leaving the facility in their wheelchairs and going down the road." c. Review of a progress note dated 10/19/15 and timed 11:34 AM showed the resident told the nurse s/he spoke with the "CEO" and it was decide the resident could go to his/her mom's house in his/her scooter. The resident told the RN that "it takes 18 minutes for me to get there." The nurse verified the conversation with the DON. d. Record review failed to show a safety assessment was completed related to the resident traveling outside in the electric wheelchair. e. Interview with the DON on 2/19/16 at 8:40 AM revealed the facility had not assessed the route or the resident's ability to travel the route safely.	F 323	5. Staff will notify family when resident #6 leaves the facility en route to family home. A time-line has been established to determine length of time it takes resident to reach destination. Resident #6;s family will contact facility if resident does not arrive within 20 minutes. 6. DON will educate all nursing staff on this process. 7. DON will monitor compliance weekly and report to QA monthly by reviewing the documentation for accuracy.	

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F 329 SS=E	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 residents were free of unnecessary medications for 3 of 7 sample residents (#6, #9, #39). The findings were: 1. Review of the significant change MDS assessment dated 11/22/15 showed resident #9 had diagnoses that included schizophrenia,	F 329	F329 The facility will ensure residents are free from unnecessary drugs. This will be accomplished by: 1. Residents #6, #9, and #39 and all residents' medication regimen will be monitored for drug interactions by the pharmacist. 2. Findings of interactions will be reported to providers. 3. Providers will review medications during monthly rounds and enter a risk versus benefits statement into the medical record. This statement will include GDR, or increase of dose, or reason for no changes in medication or dose. 4. Physicians will be educated by pharmacy about the need for a risk versus benefit statement and the process for drug reviews and documentation. Education will include regulatory guidelines for gradual dose reduction. 5. Nursing staff will be educated regarding the regulatory guidelines for gradual dose reduction and drug regimen review. 6. ADON and Pharmacist will monitor for compliance monthly and report to QA monthly.	3-25-16

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F 329	Continued From page 7 mental disorder, and personality change due to known psychological condition. Continued review showed the resident received thioridine (antipsychotic) 250 mg (milligrams) by mouth two times per day that was ordered on 8/4/14. The following concerns were identified: a. Review of the February 2016 MAR showed the resident received tramadol 50 mg by mouth 3 times per day and 50 mg by mouth every 6 hours as needed, potassium 10 mEq (milliequivalents) by mouth one time a day, and Vesicare 5 mg by mouth 1 time per day. "Drug Interaction Report" from Drugs.com accessed on 2/18/16 showed these medications have "major" interactions with thioridine. b. Review of Monthly Drug Regimen Review between 1/29/15 and 1/22/16 showed there was no evidence of identification for need of gradual dose reduction, risk versus benefit statement, or drug interactions communicated to the physician related to thioridine, Vesicare, and potassium. c. Interview with pharmacist #1 and pharmacist #2 on 2/11/16 at 10:05 AM confirmed there was no evidence of identification for a gradual dose reduction, risk versus benefit statement, or contraindications for use of potassium and Vesicare noted in the medical record. 2. Review of the quarterly MDS assessment dated 12/7/15 showed resident #39 had diagnoses that included schizoaffective disorder and major depressive disorder. Continued review showed the resident received Risperal 0.5 mg by mouth one time per day at 8 AM that was ordered on 10/18/14, Risperdal 1.5 mg by mouth at bedtime that was ordered on 8/5/14, and trazodone 100 mg by mouth at bedtime that was ordered on 8/5/14. The following concerns were	F 329		

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F 329	Continued From page 8 identified: a. Review of Monthly Drug Regimen Review between 1/29/15 and 1/18/16 showed there was no evidence of identification for need of gradual dose reduction, or risk versus benefit statement communicated to the physician. b. Interview with pharmacist #1 and pharmacist #2 on 2/11/16 at 10:05 AM confirmed a gradual dose reduction or risk versus benefit statement had not been completed related to either medication. 3. Review of the 2/7/16 quarterly MDS assessment showed resident #6 had diagnoses which included anxiety disorder. Review of physician's orders showed an 8/22/14 order for Ativan (anti-anxiety) 1 mg by mouth three times a day. Review of pharmacist monthly drug regimen reviews showed communication with the physician on 11/5/15 to request a gradual dose reduction (GDR) of the Ativan to 2 mg maximum in 24 hours to comply with generally accepted standards. The following concerns were identified: a. Review of the entire medical record showed the physician did not respond to the request from the pharmacist on 11/5/15 for a GDR concerning the Ativan order for resident #6. Review of the December 2015, January 2016, and February 2016 MARs showed the resident continued to receive Ativan per the 8/22/14 order. The record review showed the facility failed to obtain a risk versus benefits statement to explain why a GDR was not attempted for the resident. b. Interview with the pharmacist on 2/11/16 at 10:10 AM confirmed the physician did not order a GDR or complete a risk versus benefits statement to explain why a GDR was not attempted.	F 329		

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F 329	Continued From page 9 4. Review of policy titled "Monthly Drug Regimen Review" revised 2/2015 showed "...The pharmacist will conduct monthly drug regimen reviews on all long term care residents and swing bed residents...1. Reviews of all residents/swing bed patients' drug regimen will be done approximately every 30 days...3. Review will be done with consideration of: a. meeting federal indicators b. potential drug interactions...4. A summary of the above documentation will be entered on the MONTHLY DRUG REGIMEN REVIEW sheet..."	F 329		
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 1 of 1 ice machine (main servery) was kept in sanitary condition. The findings were: Interview with the dietary manager on 2/8/16 at 2:25 PM revealed the only ice machine in the facility was not in use, and ice was purchased from the community. The following concerns were	F 371	F371 The facility will procure food from sources approved or considered satisfactory by Federal, State, or local authorities. The facility will store, prepare and distribute and serve food under sanitary conditions. This will be accomplished by: 1. The ice machine was removed from its location and thoroughly cleaned. It was then returned to its location. 2. Dietary will clean daily. Maintenance will clean monthly. 3. Dietary manager will educate staff about the cleaning schedule. 4. Dietary Manager will monitor with visual inspection weekly and maintenance will inspect month and both will report monthly to QA.	3-25-16

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F 371	Continued From page 10 identified: Observation of the evening meal service in the main servery on 2/10/16 from 4:50 PM through 5:45 PM showed ice for resident beverages was obtained by dietary aide #1 from the only ice machine for the long-term care facility. Further observation showed the ice machine had streaks of a whitish substance on the entire left side of the outside of the machine, and around the circumference of the door. In addition, the inside left wall of the ice machine had whitish streaks from the top that extended into the stored ice. Interview with the dietary manager on 2/10/16 at 5:50 PM confirmed the ice machine needed to be cleaned, and staff should use the ice purchased from the community until this was accomplished. According to Food Code 2009, U.S. Public Health Service 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food, residue, and other debris."	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428	F428 The facility will identify, report, and act upon irregularities in medication regimen for residents #6, #9, and #39 and all residents. This will be accomplished by: 1. Residents #6, #9, and #39 and all residents' medication regimen	3/25/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	Continued From page 11 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to identify, report, and act upon irregularities in medication regimen for 3 of 7 sample residents (#6, #9, #39). The findings were: 1. Review of the significant change MDS assessment dated 11/22/15 showed resident #9 had diagnoses that included schizophrenia, mental disorder, and personality change due to known psychological condition. Continued review showed the resident received thioridine (antipsychotic) 250 mg (milligrams) by mouth two times per day that was ordered on 8/4/14. The following concerns were identified: a. Review of the February 2016 MAR showed the resident received tramadol 50 mg by mouth 3 times per day and 50 mg by mouth every 6 hours as needed, potassium 10 milliequivalent by mouth one time a day, and Vesicare 5 mg by mouth 1 time per day. A "Drug Interaction Report" from Drugs. com accessed on 2/18/16 showed these medications have "major" interactions with thioridine. b. Review of Monthly Drug Regimen Review between 1/29/15 and 1/22/16 showed there was no evidence of identification for need of gradual dose reduction, risk versus benefit statement, or drug interactions communicated to the physician related to thioridine, Vesicare, and potassium. c. Interview with pharmacist #1 and	F 428	will be monitored for drug interactions by the pharmacist. 2. Findings of interactions for all residents will be reported to providers by pharmacists. 3. Providers will enter a risk versus benefits statement into the medical record. This statement will include GDR, or increase of dose, or reason for no changes in medication or dose. 4. Physicians will be educated by pharmacy about the need for a risk versus benefit statement and the process for drug reviews and documentation. Education will include regulatory guidelines for gradual dose reduction. 5. Nursing staff will be educated regarding the regulatory guidelines for gradual dose reduction and drug regimen review. 6. ADON and Pharmacist will monitor for compliance monthly and report to QA monthly.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	Continued From page 12 pharmacist #2 on 2/11/16 at 10:05 AM confirmed there was no evidence of identification for a gradual dose reduction, risk versus benefit statement, or contraindications for use of potassium and Vesicare noted in the medical record. 2. Review of the quarterly MDS assessment dated 12/7/15 showed resident #39 had diagnoses that included schizoaffective disorder and major depressive disorder. Continued review showed the resident received Risperdal 0.5 mg by mouth one time per day at 8 AM that was ordered on 10/18/14, risperdal 1.5 mg by mouth at bedtime that was ordered on 8/5/14, and trazodone 100 mg by mouth at bedtime that was ordered on 8/5/14. The following concerns were identified: a. Review of Monthly Drug Regimen Reviews between 1/29/15 and 1/18/16 showed there was no evidence of identification for need of gradual dose reduction or risk versus benefit statement communicated to the physician. b. Interview with pharmacist #1 and pharmacist #2 on 2/11/16 at 10:05 AM confirmed a gradual dose reduction or risk versus benefit statement had not been completed related to either medication. 3. Review of the 2/7/15 quarterly MDS assessment showed resident #6 had diagnoses which included anxiety disorder. Review of physician's orders showed an 8/22/14 order for Ativan (anti-anxiety) 1 mg by mouth three times a day. Review of the pharmacist monthly drug regimen reviews showed communication with the physician on 11/5/15 to request a gradual dose reduction (GDR) of the Ativan to 2 mg maximum in 24 hours to comply with generally accepted	F 428		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	Continued From page 13 standards. The following concerns were identified: a. Review of the entire medical record showed the physician did not respond to the request from the pharmacist on 11/5/15 for a GDR concerning the Ativan order. Review of the December 2015, January 2016, and February 2016 MARs showed the resident continued to receive Ativan per the 8/22/14 order. The record review showed the facility failed to obtain a risk versus benefits statement to explain why a GDR was not attempted for the resident. b. Interview with the pharmacist on 2/11/16 at 10:10 AM confirmed the physician did not order a GDR or complete a risk versus benefits statement to explain why a GDR was not attempted for the Ativan ordered. The pharmacist also confirmed he failed to follow-up with the physician to ensure a response to the recommendation. 4. Review of policy titled "Monthly Drug Regimen Review" revised 2/2015 showed "...The pharmacist will conduct monthly drug regimen reviews on all long term care residents and swing bed residents...1. Reviews of all residents/swing bed patients' drug regimen will be done approximately every 30 days...3. Review will be done with consideration of: a. meeting federal indicators b. potential drug interactions...4. A summary of the above documentation will be entered on the MONTHLY DRUG REGIMEN REVIEW sheet..."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Drugs and biologicals used in the facility will be labeled in accordance	3-25-16

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F 431	Continued From page 14 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications were labeled prior to administration during 1 of 4 medication administration observations. The findings were:	F 431	with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration date when applicable. The facility will ensure residents receive the correct medications by nursing staff. This will be accomplished by: 1. Nurses will open the packaged medications for each individual resident and administer those medications directly after opening. 2. Nurses will administer the medications using the 7 Rights of medication administration policy guidelines. 3. Nurses will be educated by the DON regarding medication pass policy and protocol. 4. Medication pass will be monitored randomly by DON and reported to QA monthly.	

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F 431	Continued From page 15 1. Observation on 2/8/16 at 4:50 PM showed the medications in the medication cart had been removed from the pharmacy packaging and placed in individual medication cups. All residents who were to receive medications at that time had a medication cup with the resident's name on the cup. No medications were identified on the medication cup. 2. Interview with RN #1 on 2/8/16 at 4:50 PM revealed the medications were prepared for medication administration at 4 PM. 3. Interview with pharmacist #1 on 2/11/16 at 10:05 AM confirmed that preparing the medications for all residents prior to administration would increase the risk for medication error and it would be more difficult to verify medications after they are removed from the packaging.	F 431		
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.	F 441	F441 The facility will develop a comprehensive care plan for resident #51 and all residents that includes measurable objectives and timetables to meet each resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This will be accomplished by: 1. The care plan for resident #51 and all residents who have urinary catheters and require mechanical lifts will have two staff members in the room while preforming transfers. One staff member to help maneuver the lift, assure resident safety; and the other to be responsible for the catheter bag.	3.25.16

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F 441	Continued From page 16 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review the facility failed to ensure infection prevention practices were followed by staff on 1 of 2 sample residents (#51) with urinary catheter. 1. Observation of transfer for resident #51 on 2/10/16 at 4:40 PM showed CNA #1 and CNA #2 entered the residents room to transfer the resident the bed to the wheelchair. CNA #2 emptied the resident's urine collection bag; however, urine remained in the tubing. The CNAs provided perineal care and placed a lift sling under the resident. The CNAs positioned a full body mechanical lift next to the bed. CNA #2	F 441	2. Infection Prevention RN has performed education at the staff meeting 2/16/2016 on this new practice for the identified residents and the importance of not placing the collection bag on the lift. 3. Education was provided on 2/16/2016 with all staff on correct catheter care and review of "Care of Urinary Catheters" 150.046 and the importance of having the collection bag below the level of the residents bladder at all times and the tubing free of kinks. Urine flow must be downhill at all times. The care plan for resident #51 and all residents with urinary catheters states that collection bags are not to be on the floor, this is in correlation of the Care of Urinary Catheter policy 150.046. Collection. When the catheter bags are not being handled, they will be in a privacy collection bag at all times. 4. Resident #51 and all residents are monitored daily by all nursing staff for signs and symptoms of infection. Identified issues will be reported to the provider per nursing protocol. 5. DON and Infection Prevention Nurse will monitor by visually observing staff performing the process. 6. DON and Infection Prevention Nurse monitor infections by reviewing lab reports for all residents weekly and report to QA monthly. 7. DON and Infection Prevention Nurse will monitor catheter bag handling and storing process randomly and report to QA monthly.	

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F 441	Continued From page 17 placed the urine collection bag on the handle of the lift. The resident was lifted off the bed and positioned near the wheelchair. CNA #1 removed the urine collection bag from the lift handle and held it at chest height, above the level of the resident's bladder. Urine was observed to flow backwards in the tubing, toward the resident;s bladder. CNA #1 placed the urine collection bag on the floor next to the wheelchair and the resident was lowered into the wheelchair. CNA #1 then picked the urine collection bag up off the floor and placed it in the privacy bag secured to the wheelchair. 2. Review of the facility policy entitled "Care of Urinary Catheters" revised on 11/2013 showed "...To ensure the appropriate technique in the care and maintenance of Foley catheters the following policy should be followed...7. Maintain unobstructed urine flow by keeping the collection bag below the level of the bladder and the tubing free of kinks. Urine flow must be downhill. Secure the tubing with a leg strap. 8. Keep the collection bag off the floor." 3. Interview with the infection control nurse on 2/11/16 at 8:50 AM revealed the staff should keep the urine collection bag below the resident's bladder because it causes backflow of urine into the bladder and can cause infections. Further, the urine collection bag should never be placed on the floor because it increases the risk of infection.	F 441		