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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

SA 4/26/16

(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 CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Set ADON: Assistant Director of Nursing Less commonly used abbreviations will be annotated in each deficiency. A recertification survey was conducted by Healthcare Licensing and Surveys on 2/29/16 through 3/3/16. Also reviewed in the course of this survey was complaint intake WY00002141 and WY00002028.	F 000	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/26/16

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.

POC accepted with agreed upon changes.
Spoke with Shane Filipi 4/26/16 10:30 am.
State Surveyor

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

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F 155	Continued From page 1 option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. 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 documentation for advance directives was completed for 1 of 10 sample residents (#12). The findings were: 1. Review of the "Advance Directive/Do Not Resuscitate [DNR] order" form dated 2/12/16 for resident #12 indicated s/he had requested a DNR order. Further, the form was signed by someone other than the resident and 1 witness. Review of "admission order set" dated 2/12/16 showed the physician ordered "DNR" for the code status. Further review of the medical record did not show documentation was completed designating a power of attorney (POA). 2. During an interview with the DON and administrator on 3/3/16 at 9:50 AM, they confirmed POA documentation needed to be notarized or signed by 2 witnesses. 3. Review of the policy and procedure for Advance Health Care Directives, undated, showed: "d. The Power of Attorney must be acknowledged before a notarial officer or must be signed by at least two (2) witnesses, each of whom witnessed either the signing of the	F 155	F155 – Resident #12's advance directive will be reviewed and updated to include witnesses and/or notary by 4/16/16. An audit will be conducted of all resident's records by the social service director or designee to ensure all residents advanced directive or a durable power of attorney are completed according to Wyoming State Law. Education was provided to the staff on advanced directives on 4/5/16. All residents' advance directives will be reviewed at the annual care conference and updated as condition and/or resident's wishes change. All findings will be brought to the QA&A quarterly for one year for further review and analysis.	4/16/16

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F 155	Continued From page 2 instrument by the Resident or Resident's acknowledgement of the signature or the document."	F 155		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility grievances review, staff interview, and policy and procedure review, the facility failed to resolve grievances for 1 of 1 sample residents (#42) who had concerns. The findings were: 1. Review of a departmental note dated 4/27/15 and timed 4:24 PM showed resident #42 was on a 1500 ml (milliliter) fluid restriction and the resident's daughter expressed "concerns" about the resident and his/her care related to the restriction. Review of the facility grievances showed no grievance was documented for the resident and there was no documentation of follow-up or resolution. 2. Interview with the DON on 3/3/16 at 10:15 AM revealed the facility should have completed a grievance form for the concerns that were documented on 4/27/15. 3. Review of the undated "Resident Grievance/Complaint Procedures" policy showed "A resident, his or her representative (sponsor),	F 166	F166- The facility will actively seek resolution to any and all resident / advocate grievances or complaint/concern and acknowledge and follow up with that individual with a resolution. Resident #42 is deceased. Facility grievance policy was reviewed and updated on 3/21/16. Residents will be educated on the grievance policy during resident council on 4/4/16. Staff will be educated on grievance procedure at all staff meeting on 4/5/16. An audit will be conducted of past grievances of one year to ensure acceptable resolutions for the residents have been achieved. Administrator or designee will audit grievances weekly x 4, and monthly thereafter for one year to ensure grievances are being handled appropriately and in a timely manner. All results will be brought monthly to QA&A for one year for further review and analysis.	4/16/16

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F 166	Continued From page 3 family member, visitor or advocate may file a verbal or written grievance or complaint concerning treatment, abuse, neglect, harassment, medical care, behavior of other resident or staff members, theft of property, etc., without fear of threat or reprisal in any form...1. Obtain a Resident Grievance/Complaint Form from the nurses' station or from the business office...5. Within 15 working days of the date you filed the grievance; you will receive a written summary of the result of the investigation...7. It is the policy of this facility to assist you in filing a grievance or complaint..."	F 166	F225- The facility will ensure all facility staff including contracted vendors will have knowledge of the facilities abuse policy. ~~On 3/23/16 Resident #34 and roommate were interviewed regarding the incident on 1/5/16, both resident #34 and roommate are comfortable with each other as roommates and residents #34 is comfortable with her roommate's visitors.~~ Contracted dietary staff no longer is contracted with the facility as of 4/13/16. All staff including contracted vendors will receive a copy of the facility's abuse policy by 4/16/16. Documentation of abuse training and or receipt of abuse policy shall be reviewed and maintained in the contracting agencies file/agreement or the individual's personnel files. Audits will be conducted of the facility staff including contracted vendors by administrator or designee through random questions to the staff or contracted vendors about abuse policy. Audits will be conducted weekly for one month and	4/16/16
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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F 225	Continued From page 4 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, training curriculum review, facility incident review, and review of policies and procedures, the facility failed to ensure all contracted employees were provided abuse training for 2 of 2 hospital dietary staff (#1, #2). Further, the facility failed to investigate and report an allegation of abuse for 1 of 1 sample residents (#34) with a resident to resident altercation. The findings were: 1. Interview on 3/2/16 at 3:45 PM with dietary staff member #1 revealed she had no memory of receiving training specifically related to abuse and neglect of residents. She was able to state verbal and physical abuse were types of abuse. She revealed she usually worked in the kitchen, but did assist with serving residents on occasion. 2. Interview on 3/2/16 at 3:50 PM with dietary staff member #2 revealed he had no memory of receiving training specifically related to abuse and neglect of residents. He spoke of actions that	F 225	monthly thereafter to ensure facility staff and contracted vendors are aware of the facility's abuse policy. All findings will be brought to QA&A for one year for further review and analysis. The facility will ensure that all allegations of abuse are reported to the appropriate state agencies. On 3/23/16 Resident #34 and roommate were interviewed regarding the incident on 1/5/16, both resident #34 and roommate are comfortable with each other as roommates and residents #34 is comfortable with her roommate's visitors. Chart reviews will be completed on all charts to identify any unreported allegations of abuse over the last 6 months. Any potential abuse found will be investigated promptly and thoroughly with a full report of findings sent to the appropriate state agency. Staff education will be conducted regarding the abuse policy, reporting requirements, and documentation requirements. Education will be completed on 4/5/16. Audits will be conducted	4/16/16

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F 225	Continued From page 5 would be considered neglect, but was unsure of other types of abuse. He added he served residents the evening meal regularly. 3. An interview with the administrator on 3/3/16 at 8:20 AM revealed both dietary staff members worked for the hospital and he was not familiar with the training the hospital provided related to abuse and neglect. Review of the training provided by the hospital showed resident rights were included. It did not indicate if abuse and neglect of residents was incorporated into the training. 4. Review of the policy and procedure titled "Abuse Investigations" revised March 2014, showed; "Policy Interpretation and Implementation 3. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern, as a minimum: ...b. Mandate staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse..." 5. Review of the quarterly MDS assessment dated 2/18/16 showed resident #34 had diagnoses that included anxiety and depression. Continued review showed the resident had a BIMS (brief interview for mental status) score of 15, indicating the resident was cognitively intact. The following concerns were identified: a. Review of a departmental note written by the social services manager on 1/5/16 at 2:42 PM showed it was reported by the family of the resident's roommate that resident #34 had "yelled at the roommate's company" and pulled the	F 225	by Administrator or designee on resident charts on a weekly basis x 3 months and monthly thereafter to ensure compliance. All potential abuse will be reported to the appropriate state agency according to policy and current regulations. All findings from audits will be brought monthly to QA&A for one year for further review and analysis.	

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F 225	Continued From page 6 roommate's hair. Further, the note indicated resident #34 "felt frightened" by the visitors. No further documentation about the incident was noted in the medical record. b. Review of facility incident records for that time period showed no evidence the incident was investigated. c. Interview with the DON on 3/3/16 at 10:15 AM confirmed no incident report was completed. Further, it was revealed the incident was not reported to the State survey and certification agency. d. Review of the facility policy titled "Accidents and Incidents-Investigating and Reporting" revised on 10/01/09 showed "...All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator...1. The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form:...l. Follow-up information;..."	F 225		
F 309 SS=E	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.	F 309		

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to assess residents for medication side effects for 3 of 6 sample residents (#3, #9, #22) receiving psychotropic medications. Further, the facility failed to track fluid intakes for 2 of 2 residents (#9, #42) with fluid restrictions. The findings were: 1. Review of the quarterly MDS assessment dated 2/12/16 showed resident #22 had diagnoses that included non-Alzheimer's dementia, depression, and alcohol dependence with persisting dementia. Continued review showed the resident received Prozac (antidepressant) 20 mg (milligrams) by mouth every day. The following concerns were identified: a. Medical record review showed there was no evidence of a gradual dose reduction or risk versus benefit statement performed by the physician since the medication was ordered on 8/21/14. b. Medical record review showed there was no evidence of monitoring for side effects of long term psychotropic medication use. c. Review of a "Prozac Side Effects" report from drugs.com accessed on 3/9/16 showed the medication had potential side effects that included tardive diskinesia (a neurological disorder characterized by involuntary movements of the face and jaw). 2. Review of the 2/16/16 quarterly MDS assessment showed resident #3 had diagnoses that included schizophrenia. Review of the physician orders recapitulation for February 2016 showed the resident was ordered the medication	F 309	F309- Behavior monitoring sheets are in place for all residents on psychotropic medications (including residents 3, 9 & 22) as of 3/9/16 to monitor side effects of medication. A monitoring system has been developed to track when the last GDR was completed to ensure GDRs are done at least twice a year for newly prescribed psychotropic medications and at least yearly thereafter (unless contraindicated). AIMS will be completed by DON or designee on all residents on psychotropic medications by 4/16/16 then quarterly at the resident's quarterly assessment. Audits will be done by DON or designee on residents taking psychotropic medications monthly times 3 months and quarterly thereafter to ensure behavior monitoring sheets and GDRs are being completed appropriately. All results will be taken to QA&A monthly for one year for further review and analysis. GDR = Gradual Dose Reduction AIMS = Abnormal Involuntary Movement Scale	4/16/16

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F 309	Continued From page 8 Abilify (antipsychotic). Further review of the medical record showed no documented monitoring of possible side effects related to the medication. 3. Review of the 2/29/16 quarterly MDS assessment showed resident #9 had diagnoses that included schizophrenia and heart failure. Review of the physician orders recapitulation for February 2016 showed the resident was ordered the medication Zyprexa (antipsychotic). Further review showed the resident was restricted to 1,500 ml of fluid every 24 hours. The following concerns were identified: Related to antipsychotic medication: a. Review of the medical record showed no documentation of monitoring for possible side effects related to antipsychotics. Related to fluid resitriction: a. Observation on 2/29/16 at 4:52 PM showed the resident sitting in a wheelchair in front of a water dispenser. The resident was drinking water from a plastic cup. Observation on 3/2/16 at 4:30 PM showed the resident was again sitting in front of the water dispenser, drinking water from a plastic cup. b. Interview with the DON and ADON on 3/3/16 at 9:45 AM revealed the resident was "usually pretty conscious about [his/her] fluid restriction." They stated they were unaware the resident drank water from the water dispenser. c. Review of the dietary intake records showed the resident's fluid intake was recorded at each meal and snack offered by the facility; however, it did not include any additional fluids the resident drank independently.	F 309	All staff will be educated on documenting fluid intake at meals, snacks and between meals by 4/16/16. The medical director or NP has reviewed all residents on fluid restriction for appropriateness on 3/9/16. Resident #9 was reviewed and it was felt by medical provider that the fluid restriction was no longer medically necessary. Resident #9's fluid restriction was discontinued on 3/9/16. Resident #42 is deceased. A documentation tool was developed and implemented on 3/10/16 to ensure residents on fluid restriction are monitored for proper adherence to the fluid restriction intake recommendations. All other residents oral intake will be monitored for hydration on a weekly basis by the MDS coordinator or designee. Audits will be done by DON or designee on residents by reviewing fluid intake report weekly for 4 weeks, monthly thereafter for 3 months, and quarterly thereafter. All	

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F 309	Continued From page 9 4. Interview with the DON on 3/1/16 at 3:15 PM revealed the facility did not use a formal assessment to monitor adverse effects of psychotropic medications. 5. Review of the policy titled "Antipsychotic Medication Use" revised 10/1/09 showed "...Policy Interpretation and Implementation...7. Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication...14. Nursing staff shall monitor and report any of the following side effects to Attending Physician: a. sedation; b. Orthostatic Hypertension; c. Lightheadedness; d. Dry Mouth; e. Blurred vision; f. Constipation; g. Urinary retention; h. Increased psychotic symptoms (atropine psychosis); i. Extrapyramidal effects; j. Akathasia k. Dystonia; l. Tremor; m. Rigidity; n. Akinesia; or tardive dyskinesia" 6. Medical record review for resident #42 showed between 4/20/15 and 4/28/15 the resident was on a 1500 ml per day fluid restriction. The following concerns were identified: a. Review of the "Intake and Output Roster" for that time showed the resident received 320 ml on 4/20/15, 1120 ml on 4/21/15, 440 ml on 4/22/15, 410 ml on 4/23/15, 240 ml on 4/24/15, 1360 ml on 4/25/15, 420 ml on 4/26/15, 360 ml on 4/27/15, and 1110 ml on 4/28/15. b. Review of departmental note dated 4/27/15 at 4:24 PM showed the family of the resident was concerned with the resident's care and the facility "discussed the 1500 ml fluid restriction and the guide the nurses follow to maintain fluid restriction." c. Review of the 1500 ml fluid restriction guide showed the resident should have received	F 309	findings will be brought to QA&A monthly for one year for review and further analysis.	

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F 309	Continued From page 10 60 ml before breakfast for medication pass, 120 ml at each meal from dietary and 240 ml from nursing, 150 ml in the room for the morning, 150 ml in the room for the evening, and 60 ml for bedtime medication pass. d. Interview with the DON on 3/3/15 at 10:15 AM revealed the fluid documented would not be adequate hydration for the resident and the documentation was not accurate. 7. Review of the policy titled "Hydration" revised on 9/12 showed "...Treatment/Management...2. The staff will provide supportive measures such as providing fluids and adjusting environmental temperature..."	F 309		
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of policies and procedures, the facility failed to ensure nutritional interventions were implemented for 3 of 4 sample residents (#2, #9, #34,) with identified nutritional needs. The	F 325	F325- The facility will ensure residents maintain acceptable parameters of nutritional status and receive therapeutic diets when there is an issue. On 3/25/16 the Registered Dietitian evaluated residents #2's, #9's and #34's nutritional status and determined if further interventions are necessary. Dietary manager /MDS coordinator or designee will audit resident intake and weights on all residents for significant weight loss. Any residents identified for significant weight loss or nutritional needs will be evaluated by the Registered	4/16/16

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F 325	Continued From page 11 findings were: 1. Review of the 2/29/16 quarterly MDS assessment for resident #9 showed diagnoses that included diabetes and schizophrenia. Further review showed the resident weighed 155 pounds. Review of the care plan showed the resident was at risk for skin breakdown, with interventions to include "Provide [resident's] diet as ordered. Record food intake % [percentage] at each meal... Dietitian will evaluate [resident's] nutritional status quarterly." The following concerns were noted: a. Review of the weight log showed on 11/22/15, the resident weighed 175 pounds. Further review showed on 2/22/16, the resident weighed 155 pounds, a loss of 20 pounds (11.4%) in 3 months. b. Review of dietary notes showed the last assessment was completed on 7/15/15. c. Review of a "Care Plan Conference Summary" dated 12/3/15 showed the resident ate 89% to 95% of meals. There was no documentation to show weight was discussed. Review of a "Care Plan Conference Summary" dated 12/18/15 showed the resident ate 97% of meals and was on a 1500 mL fluid restriction. There was no documentation to show weight was discussed. Review of a "Care Plan Conference Summary" dated 1/21/16 showed the resident ate 98.8% of meals, drank an average of 1454 mL of fluids, weighed 158.8 pounds, and was stable. Further review showed "Nutrition and hydration no problem." Review of a "Care Plan Conference Summary" dated 2/25/16 showed the resident ate 100% of meals, drank on average 1325 mL of fluids, and weighed 155 pounds. d. Interview with the MDS coordinator on 3/3/16 at 8:10 AM revealed he tracked weights to	F 325	Dietitian by 4/1/16. Staff was educated on 4/5/16 on proper nutritional interventions. A documentation tool has been developed and implemented to track weight loss/gain, current BMI, altered diets and chewing or swallowing difficulties as identified on section K of the MDS. MDS coordinator will email this document to the Registered Dietician weekly for review and recommended interventions. Facility will follow up with physician regarding RD recommendations. Weights will be reviewed weekly on all residents by dietary manager or designee to ensure all residents are maintaining acceptable nutritional parameters. RD or Dietary Manager will review each resident at their quarterly MDS assessment for nutritional needs. Dietary manager will estimate the calorie, nutrition and fluid needs and confer with RD and/or physician to ensure the resident is on the appropriate diet. Dietary Manager or designee will	

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F 325	Continued From page 12 determine weight loss or gain. He added the parameters he used for determining weight loss were 5% weight loss in 1 month or 10% weight loss in 6 months. He further revealed he was unaware of the resident's 20 pound weight loss over 3 months. 2. Review of the admission MDS assessment dated 8/24/15 showed resident #34 had a weight of 165 pounds. Review of the weekly weight log dated 1/24/16 and timed 8 AM showed the resident weighed 134 pounds, a 31 pound or 18.7% loss since the time of admission. Review of the quarterly MDS assessment dated 2/18/16 showed the resident's weight increased to 140 pounds; a 25 pound or 15.1% loss since the time of admission. Review of the care plan conference summary dated 11/24/15 showed no identification or discussion of weight loss or need for nutritional interventions. Review of the care plan conference summary dated 2/25/16 showed the weight was "stable in the 140s." Review of the medical record showed there was no evidence the resident was assessed by a dietician or that nutritional interventions were implemented to prevent weight loss or stabilize the resident's weight. 3. Review of the admission MDS assessment dated 10/16/15 showed resident #2 had a weight of 152 pounds. Review of the weekly weight log dated 1/10/16 and timed 8 AM showed the resident weighed 131 pounds, a 21 pound or 13.8% loss since the time of admission. Review of the quarterly MDS assessment dated 1/15/16 showed the resident weighed 131 pounds and the weight loss was not physician-prescribed. Review of the care plan conference summary dated 1/21/16 showed the resident "likes mighty shakes" and staff will "cut up" the resident's food.	F 325	audit RD documentation to ensure compliance weekly for 4 weeks, monthly thereafter for 3 months, and quarterly thereafter. All findings will be brought to QA&A monthly for one year for review and further analysis.	

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F 325	Continued From page 13 Review of the medical record showed there was no evidence the resident was assessed by a dietitian or that nutritional interventions were implemented to prevent weight loss or stabilize the resident's weight. 4. Interview with the dietary manager on 2/29/16 at 11:15 AM revealed she was a registered dietitian and had performed the dietitian's duties at the facility up until October 2015. 5. Interview with the DON on 3/1/16 at 3:43 PM revealed the current consultant registered dietitian was based out of another city and did not come to the facility often. She further added that the MDS coordinator kept track of the residents' weights. She stated the facility monitors each resident's nutrition status using the "Care Plan Conference Summary" forms. 6. Interview with the MDS coordinator on 3/3/16 at 8:10 AM revealed he tracked weights to determine weight loss or gain. He further stated if a concern was identified, he discussed with the resident's nurse options such as supplements or increased assistance with eating, or would refer to the physician if needed. He stated the consultant dietitian was available, but he had not utilized her services since the previous dietitian left that position. 7. Interview with the DON on 3/3/16 at 10:15 AM revealed she was unsure if any interventions had been implemented to increase resident's weights when identified to have a weight loss. Further, it was confirmed that there had not been a dietitian consult for the residents. 8. Review of the policy titled "Nutrition	F 325		

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F 325	Continued From page 14 (Impaired)/Unplanned Weight Loss" revised 09/12 showed "Assessment and Recognition...3. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss = [usual weight-actual weight / [usual weight] x 100): a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 month - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe...Cause Identification 1. The Physician will review possible causes of anorexia or weight loss with the nursing staff and/or Dietitian before ordering interventions. a. The Dietitian will estimate calorie, nutrient and fluid needs and, with the physician, will identify whether the resident's current intake is adequate to meet his or her nutritional needs...Treatment/Management...b. Nutritional needs: The Dietician will help the physician determine the appropriate diet for the resident based on the resident's degree of nutritional impairment, expressed wishes, and underlying causes and conditions. If the resident's nutritional or caloric needs have changed, but the diet has not, this may help to clarify the appropriate interventions."	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview,	F 327		

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F 327	Continued From page 15 and policy and procedure review, the facility failed to provide sufficient fluid intake to maintain hydration for 1 of 2 sample residents (#42) on fluid restrictions. The findings were: 1. Review of the medical record for resident #42 showed between 4/20/15 and 4/28/15 the resident was on a 1500 ml per day fluid restriction. Review of the "Intake and Output Roster" for that time showed the resident received 320 ml on 4/20/15, 1120 ml on 4/21/15, 440 ml on 4/22/15, 410 ml on 4/23/15, 240 ml on 4/24/15, 1360 ml on 4/25/15, 420 ml on 4/26/15, 360 ml on 4/27/15, and 1110 ml on 4/28/15. Review of a departmental note dated 4/27/15 at 4:24 PM showed the family of the resident was concerned with the resident's care and the facility "discussed the 1500 ml fluid restriction and the guide the nurses follow to maintain fluid restriction." Review of the 1500 ml fluid restriction guide showed the resident should have received 60 ml before breakfast for medication pass, 120 ml at each meal from dietary and 240 ml from nursing, 150 ml in the room for the morning, 150 ml in the room for the evening, and 60 ml for bedtime medication pass. 2. Interview with the DON on 3/3/16 at 10:15 AM revealed the documented fluid intake would not provide adequate hydration for the resident. 3. Review of the policy titled "Hydration" revised on 9/12 showed "...Treatment/Management...2. The staff will provide supportive measures such as providing fluids and adjusting environmental temperature..."	F 327	F327- The facility will provide sufficient fluid intake to maintain proper hydration and health. Resident #42 is deceased. All staff will be has educated on documenting fluid intake at meals, snacks and between meals on all residents on fluid restrictions on 4/5/16. MDS coordinator/dietary manager or designee will monitor all resident hydration on weekly basis by reviewing the fluid intake report. Audits will be done by DON or designee on residents by reviewing fluid intake report weekly for 4 weeks, monthly thereafter for 3 months, and quarterly thereafter. All findings will be brought to QA&A monthly for one year for review and further analysis.	4/16/16
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 16 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, staff interview and review of policies and procedures, the facility failed to ensure the medication regimen was free of unnecessary drugs for 2 of 6 residents (#22, #28) with psychotropic medications prescribed. The findings were: 1. Review of the quarterly MDS assessment dated 1/12/16 for resident #28 showed s/he was admitted to the facility on 4/17/12. Diagnoses	F 329	F329- Residents #22 and #28 shall be reviewed at the quarterly psychotropic medication meeting on 3/29/16 to determine if a GDR is appropriate. All residents on psychotropic medications will be reviewed for GDR appropriateness on 3/29/16. Nursing staff was educated on 4/5/16 on GDR. A monitoring system has been developed to track when the last GDR was completed to ensure GDRs are done at least twice a year for newly prescribed psychotropic medications and at least yearly thereafter (unless contraindicated). If the Physician feels a GDR is not necessary, a risk/benefit analysis will be addressed on the DRR or Psychotropic medication review form by the physician. AIMS will be completed by DON or designee on all residents on psychotropic medications by 4/16/16 then quarterly at the resident's quarterly assessment. Drug Regimen Reviews will be completed by a professional GDR = Gradual Dose Reduction SK 4/26/16	4/16/16

AIMS = Abnormal Involuntary Movement Scale

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F 329	Continued From page 17 included dementia and depression. Review of the March 2016 medication administration record showed the resident was prescribed the medication zoloft 50 mg (antidepressant) to be given once daily. Further, it showed the medication order and start date was 8/14/13. The followings concerns were noted: a. Review of the "Psychotropic Drug Review Form[s]" for 2015 showed the pharmacist and physician only noted the resident was doing well and remained stable. b. Review of the social services note dated 1/23/14 showed the resident reported feeling down 7 or more days within the last 14 days. In addition, the resident's mood score had increased from 1 to 8. The resident stated s/he "gets tired of being here [facility] at times" and felt an increase in activity would be helpful. Continued review of the social services notes dated 10/21/14 showed the resident's mood score was 2 indicating an improvement. c. Review of the 1/12/16 MDS assessment showed the resident's mood score was 3, indicating minimal depression. d. Review of the medical record showed no evidence a gradual dose reduction or risk versus benefit statement was completed since the medication was ordered. 2. Review of the quarterly MDS assessment dated 2/12/16 showed resident #22 had diagnoses that included non-Alzheimer's dementia, depression, and alcohol dependence with persisting dementia. Continued review showed the resident received Prozac (antidepressant) 20 mg (milligrams) by mouth every day. The following concerns were identified: a. Review of the "Behavior Roster" from 1/1/16 through 3/3/16 showed the resident had 2	F 329	medical provider monthly, on each resident. A psychotropic medication review sheet will be completed by the medical provider quarterly. DON or designee will audit the DRR sheets monthly and the psychotropic review sheets quarterly, to ensure pharmacist recommendations are being addressed. All results will be taken to QA&A monthly for one year for further review and analysis.	

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F 329	Continued From page 18 episodes of yelling at others and 1 episode of wandering into others rooms. b. Review of the monthly "Psychotropic Drug Review Form" from 2/21/15 to 11/9/15 showed no evidence of a gradual dose reduction or risk versus benefit statement performed by the physician since the medication was ordered on 8/21/14. 3. Interview with the DON and administrator on 3/3/16 at 9:50 AM revealed there was no system-wide process for reviewing psychotropic medications. 4. Review of the policy titled "Antipsychotic Medication Use" revised 10/1/09 showed "...Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition...Policy Interpretation and Implementation...6. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. 7. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing psychotic medication....11. Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. wandering;...g. unsociability;...15. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences."	F 329		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387		

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F 387	Continued From page 19 The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents were seen by a physician at least once every 60 days for 4 of 10 sample residents (#5, #22, #28, #34). The findings were: 1. Review of medical record showed resident #22 was seen by a physician on 2/4/15. There was no evidence another visit was performed by a physician or nurse practitioner until 8 months later on 10/14/15. 2. Review of the medical record showed resident #34 was seen by a nurse practitioner on 8/26/15, 9/23/15, 10/7/15, 10/21/15, and 12/28/15. There was no evidence a physician had conducted a visit during the resident's stay. 3. Review of the physician visit notes showed resident #28 was not seen by a physician or nurse practitioner from 12/16/14 through 3/15/15 (88 days). Further review showed the resident was not seen by a provider from 5/13/15 through 8/19/15 (98 days). 4. Review of the physician visit notes showed	F 387	F387- Residents 5, 22, 28 and 34 were seen by the physician on 3/23/16. Education was provided to the nursing staff on 4/5/16 on appropriate provider visits. All residents' physician visit schedules will be reviewed by DON or designee to ensure they have been seen by a physician or nurse practitioner in the last 60 days. A monitoring tool has been developed to document due dates of 60 day reviews and which type of provider is required to perform the 60 day review to ensure residents are seen. DON, MDS coordinator or designee will audit progress notes monthly on residents due for 60 day reviews to ensure compliance. All findings will be brought to QA&A monthly for one year for further review and analysis.	4/16/16

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F 387	Continued From page 20 resident #5 was not seen by a physician or nurse practitioner from 2/18/15 through 5/27/15 (98 days). Further review showed the resident was not seen by a provider from 7/1/15 through 9/30/15 (92 days). 5. During an interview with the DON and administrator on 3/3/16 at 9:50 AM, they acknowledged the residents were not consistently seen by the physician every 60 days. 6. Review of the policy titled "Physician Visits" revised 4/08 showed "...2. After the first ninety (90) days, if the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation..."	F 387		
F 388 SS=E	483.40(c)(3)-(4) PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced	F 388		

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SK 4/26/16

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F 388	Continued From page 21 by: Based on medical record review, staff interview, and policy review, the facility failed to ensure a physician personally performed visits for 5 of 10 sample residents (#3, #5, #22, #28, #34) at least every 120 days. The findings were: 1. Review of the medical record showed resident #34 was seen by a nurse practitioner on 8/26/15, 9/23/15, 10/7/15, 10/21/15, and 12/28/15. There was no evidence the physician conducted a visit during the resident's stay. 2. Review of medical record showed resident #22 was seen by physician on 2/4/15. There was no evidence another visit was performed until 8 months later on 10/14/15. 3. Review of the physician visit notes showed resident #5 was seen by a provider 9 times between 2/18/15 and 2/10/16. Further review showed the resident had seen the physician during 4 consecutive visits between 2/18/15 and 7/1/15. Review of the subsequent 5 visits, from 9/30/15 through 2/10/16, showed the resident was seen by the nurse practitioner. There was no further documentation in the medical record to show the physician had seen the resident after 7/1/15. 4. Review of the physician visit notes showed resident #28 was seen by a provider 9 times between 12/10/14 and 1/13/16. Further review showed the resident had seen the physician during 4 consecutive visits between 12/10/14 and 5/13/15. Review of the subsequent 5 visits, from 8/19/15 and 1/13/16 showed the resident was seen by the nurse practitioner. There was no further documentation in the medical record to	F 388	F388- Residents 3, 5, 22, 28 and 34 were seen by the physician on 3/23/16. Education was provided to the nursing staff on 4/5/16 on timely physician visits. All residents' physician visit schedules will be reviewed by DON or designee to ensure they have been seen by a physician in the last 120 days. A monitoring tool as been developed to document due dates of 60 day reviews and which type of provider is required to perform the 60 day review to ensure residents are seen by a physician at least on alternate required visits. DON, MDS coordinator or designee will audit progress notes monthly on residents due for 60 day reviews to ensure compliance. All findings will be brought to QA&A monthly for one year for further review and analysis.	4/16/16

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	535053	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

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F 388	Continued From page 22 show the physician had seen the resident after 5/13/15. 5. Review of the physician visit notes for resident #3 showed the last visit note signed by the physician was dated 7/22/15. Further review showed the nurse practitioner completed each subsequent visit, on 9/16/15, 11/17/15, and 1/6/16. 6. Interview with the DON and administrator on 3/3/16 at 9:50 AM confirmed the residents were not consistently seen by the physician every 120 days. 7. Review of the policy titled "Physician Visits" revised 4/08 showed "...2. After the first ninety (90) days, if the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation..."	F 388		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406		

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F 406	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure speech therapy (ST) services were provided for 2 of 2 residents (#12, #39) identified with speech therapy needs. The findings were: 1. Review of the 2/16/16 annual MDS assessment for resident #39 showed diagnoses that included dementia and anorexia. Review of the undated care plan showed the resident was underweight and required extensive assistance with eating and drinking. The following concerns were noted: a. Observation on 2/29/16 beginning at 12:20 PM showed the resident sitting in a wheelchair in the dining room. CNA #3 was assisting the resident with eating a plate of pureed food and drinking from cups of thin liquids using straws. During the observation, the resident had a wet, gurgly quality to a cough or throat-clear following 2 of 2 straw sips of liquid. At 12:33 PM, CNA #3 left the table and LPN #1 sat down next to the resident to assist with the meal. The resident had a wet-sounding quality to a cough or throat-clear following 2 of 2 additional straw-sips of thin liquid. b. Observation on 3/1/16 at 6:08 PM showed the resident sitting in a wheelchair in the dining room with CNA #4 assisting the resident with a meal of pureed food and thin liquids with straws. The resident was noted to have wet, gurgly coughs following 6 of 10 straw-sips of thin liquid. c. Interview with RN #1 on 3/1/16 at 7:15 PM revealed CNAs had reported the resident had recent increased difficulty with drinks. She further	F 406	F406- Facility had a new speech therapist start on 3/25/16. Residents #12 and #39 were evaluated by a speech therapist on 3/25/16. Education was provided to nursing staff on 4/5/16 to pass along any speech therapy concerns. An audit will be conducted by DON or designee of the last 6 months hospital discharge summaries and admission history and physical to ensure any residents with potential need for speech therapy are identified and screened for speech therapy. MDS coordinator or designee will review the last 6 months of care conference notes for any other indication of speech therapy needs. Rehab manager or designee will monitor the dining room weekly to observe residents during meals for signs and symptoms of a possible swallowing disorder. Findings will be recorded in log and resident placed on physician clinic list for follow up. DON or designee will audit logs, section K of MDS and clinic notes weekly for 4 weeks,	4/16/16

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F 406	Continued From page 24 revealed the resident would be seen at the nursing home clinic the following day to possibly obtain a speech therapy consult for swallowing. She added the resident had increased secretions and phlegm, and they were using a mouthwash to address this concern. d. Review of the medical record on 3/1/16 at 4:30 PM showed no evidence of documentation related to the resident's increased difficulty swallowing. e. Review of a nurse's note dated 3/1/16 at 7:55 PM showed the resident was noted "to be off and on coughing more with drinking or eating the last two weeks..." f. Review of a physician's order from the clinic visit dated 3/2/16 showed "Keep upright at 90 degree angle at least 30 minutes after eating or drinking. Nectar thickened liquids. ST consult when available." g. Interview with the DON and ADON on 3/3/16 at 9:45 AM revealed they were unsure when a speech therapist would be available to evaluate the resident. 2. Review of the hospital discharge summary dated 2/11/16 showed resident #12 had diagnoses that included dementia, history of stroke and dysphagia (difficulty in swallowing). In addition, it showed: "At this time, patient needs to be on nectar-thick diet. To note that the patient sometimes did choke, did cough when [s/he] is eating, and that needs special attention..." Review of the "admission order set" dated 2/12/16 showed the physician ordered a speech therapy evaluation. Further review of the physician orders dated 2/24/16, showed speech therapy was discontinued until a speech therapist was available. As of 3/3/16, the evaluation had not been completed. During an interview with the	F 406	monthly thereafter for 3 months, and quarterly thereafter. DON or designee will audit all hospital discharge summaries on new admissions for speech or swallowing concerns. Audits will be conducted after each new admission for one year. All findings will be brought to QA&A monthly for one year for review and further analysis.	

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F 406	Continued From page 25 DON on 3/3/16 at 9:50 AM, she revealed several attempts had been made to schedule a speech therapy evaluation. The attempts made to arrange for the evaluation and any conversations were not documented. 3. Review of the facility's policy and procedure titled "Dysphagia- Clinical Protocol," revised September 2012, showed: "Cause Identification ...3. If a readily apparent cause cannot be identified, and dysphagia is suspected, the physician may order a speech therapy evaluation..."	F 406		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the agency failed to ensure a physician response to pharmacist recommendations for 1 of 10 sample residents (#28). The findings were: 1. Review of the 1/12/16 quarterly MDS assessment showed resident #28 had diagnoses that included diabetes and osteoarthritis. Further,	F 428	F428- Resident # 28's gabapentin dose was reviewed by a physician on 3/23/16 to address concerns expressed by the pharmacist on the DRR dated 12/16/15. Nursing staff was educated on 4/5/16 on DRRs. An audit of all resident's DRRs over the last 3 months will be completed by 4/16/16. Any concerns or recommendations noted by the pharmacist that have not been addressed will be brought to the attention of the physician or nurse practitioner to review. Drug Regimen Reviews will be completed by the physicians and/or nurse practitioner on a monthly basis. DON or designee will review the	4/16/16

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F 428	Continued From page 26 review of section J for health conditions showed the resident had a fall with injuries. Review of the "Drug Regimen Review Form" showed the pharmacist had recommended to reduce the resident's gabapentin (treatment for pain due to diabetic neuropathy) to half the daily dose, from 600 mg (milligrams) to 300 mg 3 times each day "due to falls." Further review did not show the physician had addressed the pharmacist recommendation. Review of subsequent orders did not show an order to reduce the medication dose. 2. During an interview with the DON on 3/3/16 at 9:50 AM, she confirmed there was no documentation to show the pharmacist recommendation was addressed by the physician.	F 428	DRRs monthly to ensure pharmacist recommendations are addressed and will follow up with the physicians as needed to ensure compliance. All findings will be brought to QA&A monthly for one year for review and further analysis.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure lab services were performed as ordered by the physician for 2 of 10 sample residents (#5, #39). The findings were: 1. Review of the "Drug Regimen Review Form" dated 11/30/15 for resident #5 showed the pharmacist had recommended a TSH (thyroid stimulating hormone) blood level to be rechecked	F 502	F502- Resident #5 was reviewed by physician on 3/24/16 to determine if a follow up TSH is indicated at this time. Resident has routine labs scheduled for April and a TSH will be drawn on 4/5/16. Resident #39's labs were reviewed by a physician on 3/23/16 for clarification of the routine lab order. Physician orders from the last month will be reviewed by DON / ADON or designee by 4/16/16 to ensure labs ordered are on schedule to be drawn. Clarification of routine	4/16/16

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F 502	Continued From page 27 in 6 weeks. In addition he noted the previous level, obtained on 11/10/15 was "on the high side..." Further, it showed the physician indicated on 12/2/15 he concurred with the recommendation. Review of lab work completed did not show the TSH was drawn. 2. Review of the "Drug Regimen Review Form" dated 9/30/15 for resident #39 showed the pharmacist had noted the hematocrit (blood test) was "due this month." Review of the hematology lab reports showed the last hematocrit level obtained was on 1/20/15. During an interview with the DON on 3/1/16 at 10:50 AM she indicated the routine blood work had been discontinued. Review of a physician order written on 2/4/15 confirmed the lab work was to be discontinued due to a request made by a family member. However, further review of the physician orders dated 5/30/15 showed the hematocrit was to be drawn every 6 months in October and April. 3. An interview with the DON on 3/3/16 at 9:50 AM, confirmed the lab work should have been done.	F 502	lab orders will be requested of the physician or nurse practitioner as needed. Nursing staff will be educated on 4/5/16 on lab order process, review of DRRs, and order clarification and follow up. A monthly audit times one year, of lab orders on residents will be done by DON or designee to ensure compliance. All findings will be brought to QA&A monthly for one year for further review and analysis.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	F514- Resident #39 was seen on 3/2/16 by a nurse practitioner, with new orders received and will be evaluated by a speech therapist on 3/25/16. DON or designee will audit all charts from the last three months to ensure all pertinent information related to the residents condition is contained in the medical record.	4/16/16

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

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F 514	Continued From page 28 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility policy and procedure, and medical record review, the facility failed to ensure the medical record included pertinent information related to the resident's condition for 1 of 13 sample residents (#39). The findings were: 1. Review of the 2/16/16 annual MDS assessment for resident #39 showed diagnoses that included dementia and anorexia. Review of the care plan showed the resident was underweight and required extensive assistance with eating and drinking. The following concerns were noted: a. Observation on 2/29/16 beginning at 12:20 PM showed the resident sitting in a wheelchair in the dining room. CNA #3 was assisting the resident with eating a plate of pureed food and drinking from cups of thin liquids using straws. During the observation, the resident had a wet, gurgly quality to a cough or throat-clear following 2 of 2 straw-sips of liquid. At 12:33 PM, CNA #3 left the table and LPN #1 sat down next to the resident to assist with the meal. The resident had a wet-sounding quality to a cough or throat-clear following 2 of 2 additional straw-sips of thin liquid. b. Observation on 3/1/16 at 6:08 PM showed the resident sitting in a wheelchair in the dining room with CNA #4 assisting the resident with a meal of pureed food and thin liquids with straws. The resident was noted to have wet, gurgly coughs following 6 of 10 straw-sips of thin liquid.	F 514	A change in condition log will be implemented by 4/16/16, that will address any conditions / changes in the residents that require documentation and follow up by nursing staff. Nurses will be educated on proper documentation and use of the change in condition log at the nurses meeting on 4/5/16. Individual education will be conducted for nurses unable to attend the 4/5/16 meeting by 4/16/16. DON or designee will conduct documentation audits to ensure changes of condition are appropriately documented. DON or designee will conduct the audits weekly x 4 weeks, then monthly x 3 months and quarterly thereafter. All findings will be brought to QA&A monthly for one year .for further review and analysis.	

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F 514	Continued From page 29 c. Interview with RN #1 on 3/1/16 at 7:15 PM revealed CNAs had reported the resident had recent increased difficulty with drinks. Further, it was revealed the resident would be seen at the nursing home clinic the following day to possibly obtain a speech therapy consult for swallowing. She added the resident had increased secretions and phlegm, and they were using a mouthwash to address this concern. d. Review of the medical record on 3/1/16 at 4:30 PM showed no evidence of documentation related to the resident's increased difficulty swallowing. e. Review of a nurse's note dated 3/1/16 at 7:55 PM showed the resident was noted "to be off and on coughing more with drinking or eating the last two weeks..." f. Interview with the DON and ADON on 3/3/16 at 9:45 AM revealed the expectation was for nurses to document if they have a concern regarding a resident or if CNAs report concerns. 2. Review of the facility's policy and procedure titled "Dysphagia- Clinical Protocol," revised September 2012, showed: "Assessment and Recognition ...3. The staff will identify individuals who have difficulty swallowing or chewing food. a. Any staff member observing an incident or situation will document details of the circumstances or have a nurse observe and document those details..."	F 514		