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
	535031	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

(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: CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set mg- milligrams ml- milliliters PRN- Latin phrase "pro re nata" which translates to as needed SCU- secure care unit Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an ongoing program of activities designed to meet individual interests and improve or maintain the physical, mental, and psychosocial well-being of residents in 1of 2 resident areas (secure unit). The census in the secure unit was 12. The findings were: 1. Observation of the secure unit on 11/1/16 from 8:10 AM through 10:55 AM and random	F 248	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state laws. F248 Activity schedule was immediately reviewed and changed accordingly to ensure the activities met the residents physical, mental and psychosocial well-being	12.2.16 12-2-16

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

John Odell ED — 11-28-16

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.

Changes made per Phone with Jonny Aldrich, NHA on 12/2/16 @ 3:30p. Jonelle Call

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F 248	Continued From page 1 observations on 11/2/16 revealed meaningful activities were not provided for the residents. 2. Interview on 11/1/16 at 9:30 AM with CNA #2 revealed CNAs were responsible for activities in the secure unit. In addition, she stated CNAs were given a calendar with a list of activities to choose from and were expected to select an activity from the list if they had time. The CNA further stated she spent hours of her own time researching activities to do with the residents as "they have to be mentally appropriate." The CNA explained that the unit was staffed with 2 CNAs during the day and they did not always have time to do activities as well as their care tasks. Further interview on 11/2/16 at 10:55 AM with CNA #2 revealed, "Unless there is a special occasion the residents in the unit don't leave." 3. Interview on 11/2/16 at 3:25 PM with CNA#3 revealed "some days were better than others" when it came to activities. It depended, she added, on the behavior of the residents and their anxiety level. 4. Interview on 11/3/16 at 10:05 AM with the activity coordinator verified that she did not have an available staff member dedicated to the unit and she did not have a system in place to monitor if the activities were being done or if they were meaningful. She also stated that she relied on CNA documentation and interviews and realized activities did not always occur because care came first.	F 248	F248 Cont'd: Identification of Others: The activity program will be audited relating to meaningful activities provided in other areas of the facility. Systemic Changes: The activity program for the SCU will be evaluated relating to providing meaningful activities by the Activity Director. Activities will be evaluated monthly relating to providing activities to Residents in the SCU. DNS will provide education to staff working in the SCU relating to providing meaningful activities. Monitoring: Activity Director and/or designee will audit relating to providing meaningful activities in the SCU daily for one week. Observations of activities not being provided in the SCU will be corrected at the time of observation. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	Continued From page 2 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 5 of 6 resident areas (North hall, South hall, secure unit, East hall, Purple Sage dining room) were clean and in good repair. The findings were: 1. Concerns identified on the secure unit: a. Observation of the common area in the secure unit on 10/31/16 through 11/3/16 revealed three tables used by residents were unstable and tipped when leaned on. Interview with CNA #2 on 11/3/16 at 9:10 AM revealed the tables had been unstable for at least a year. She stated the maintenance supervisor was aware of the problem and had attempted to fix the tables. In addition, she revealed one of the residents "does not like it and rips up boxes" to try to keep the tables from wobbling. Interview with the maintenance supervisor on 11/3/16 at 8:10 AM verified the tables were not stable and, in addition, he stated they were not repairable. b. Observation on 11/1/16 at 8:15 AM of the bathroom in room 17 revealed an air vent that hung from the ceiling with one screw. In addition, the slats of the vent were covered with dust. c. Observation on 11/1/16 at 8:20 AM revealed the radiator slats in the bathroom of room 18 were covered in dirt and debris. In addition, water leaked from underneath the hot and cold faucet handles when they were in the on position. d. Observation on 11/1/16 at 8:30 AM revealed the radiator slats in room 19 were	F 253	F253 1.Secure Unit\ Observations: a. Unstable tables will be repaired and/or replaced. b. Room 17 ceiling vent will be cleaned and rehung. c. Room 18 radiator slats in bathroom will be cleaned. The water faucets shall be repaired so as to not leak. d. Room 19 radiator slats will be cleaned. e. Room 22 radiator slats will be cleaned. f. The crack in the floor tile outside room 17 will be repaired so as to provide a cleanable surface. 2. North Hall Observations: a. Room 2 inside bathroom door frame plaster will be repaired. b. Room 3 laminate countertop above the drawers will be repaired and/or replaced to remove chips. Radiator slats in bathroom will be cleaned. c. Room 4 inside bathroom door frame plaster will be repaired. d. Room 5 outside doorframe into the bathroom plaster will be repaired. Radiator cover will be cleaned. Outside the bathroom door will be repaired and/or replaced	12.2.16

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F 253	Continued From page 3 covered in dirt and debris. e. Observation on 11/1/16 at 8:35 AM revealed the radiator slats in room 22 were covered in dirt and debris. f. A crack in the floor tile outside of room 17 extended the length of the hallway which created a surface that was not cleanable. 2. Concerns identified on the North hall: a. Observation on 11/2/16 at 12:03 PM of room 2 revealed the inside bathroom door frame, to the left of the entryway, was missing a strip of plaster 11 inches long which exposed the metal corner strip and created a surface that was not cleanable. b. Observation on 11/2/16 at 12:05 PM of room 3 revealed two chips in the laminate countertop above the drawers. One measured 1/2 by 1/2 inch and the second one measured 1/4 by 3/4 inch which created a surface that was not cleanable. In addition, the radiator slats in the bathroom were covered in dirt and debris. c. Observation on 11/2/16 at 12:08 PM of room 4 revealed the inside bathroom door frame was missing a strip of plaster 17 inches long which exposed the metal corner strip and created a surface that was not cleanable. d. Observation on 11/2/16 at 12:10 PM of room 5 showed the outside doorframe into the bathroom was missing a 1 by 4 inch piece of plaster that exposed the metal strip and created a surface that was not cleanable. In addition, the radiator was covered in dirt and debris and the outside of the bathroom door had two broken areas which exposed sharp and splintered edges. One was located 24 inches from the floor and measured 4 by 6 inches and the second was located 3 inches from the floor and measured 2 by 3 inches.	F 253	F253 Cont'd: e. The cracked tiles in the entryway to room 24 will be repaired so as to provide a cleanable surface. f. Room 25 flooring pits will be repaired so as to provide a cleanable surface. The wallpaper around the grab bar beside closet door will be repaired and/or replaced and/or removed. The radiator in the bathroom will be cleaned. g. Room 26 flooring pits will be repaired so as to provide a cleanable surface. g. Room 26 flooring pits will be repaired so as to provide a cleanable surface. The inside doorframe of the bathroom plaster will be repaired. The mopboard shall be replaced. h. Room 27 flooring pits wil be repaired so as to provide a cleanable surface. The radiator will be cleaned. i. Room 28 sink will be replaced. Wallpaper near bathroom door will be repaired and/or replaced and/or removed. The mopboard in the bathroom will be repaired and/or replaced. k. Room 15 water faucets will be repaired and/or replaced. 3. South hall observations:	

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F 253	Continued From page 4 e. Observation on 11/2/16 at 11:10 AM revealed six cracked 9 by 9 inch tiles in the entryway to room 24. Three of the cracks measured 3 inches in length, one was 3 inches long and radiated outwards, one was 4 inches long and radiated outwards, and one was 7 inches long and had an irregular pattern. f. Observation on 11/2/16 at 11:25 AM revealed multiple pits of various sizes located throughout the flooring in room 25 which created a surface that was not cleanable. In addition, wallpaper was peeling around the grab bar beside the closet door and the radiator in the bathroom was covered in dirt and debris. g. Observation on 11/2/16 at 11:15 AM revealed multiple pits of various sizes located throughout the flooring of room 26. The inside doorframe of the bathroom was missing a strip of plaster 20 inches long which exposed the metal corner strip and 7 inches of the mopboard was missing. These findings created surfaces which were not cleanable. h. Observation on 11/2/16 at 11:20 AM showed multiple pits of various sizes located throughout the flooring in room 27 which created a surface that was not cleanable. In addition, the radiator was covered in dirt and debris. I. Observation on 11/2/16 at 11:30 AM revealed the bathroom sink in room 28 was cracked in three places. One crack was 18 inches long and extended from the corner of the sink, by the hot water handle, in an irregular curved pattern into the sink basin. The second crack extended from the top middle of the sink through the faucet base and into the drain for a total of 13 inches. The third crack extended from the right hand corner of the sink down to the cold water handle and measured 4 inches long and also contained a 1/4 by 1/2 inch chip. In addition,	F 253	F253 Cont'd: a. Room 31 faucet will be repaired and/or replaced. Radiator will be cleaned. b. Room 32 will have the crack in the top of the wooden dresser drawer shall be repaired and/or replaced. The faucets will be repaired and/or replaced. c. Room 33 radiator will be cleaned. The crack in the linoleum will be repaired so as to provide a cleanable surface. 4. East hall observations: a. Room 7 mopboard will be replaced. b. Room 12 radiator will be cleaned. 5. Purple Sage observations: a. Exit door will have the metal weather stripping repaired and/or replaced. b. The floor in front of the exit door will be cleaned. c. The edges of the floor around the perimeter of the room will be cleaned.	

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F 253	Continued From page 5 wallpaper was peeling away from the wall near the bathroom door and 16 inches of mopboard, in the bathroom, had pulled away from the wall. j. Observation on 11/2/16 at 11:50 AM of the sink in room 29 revealed water leaked from beneath the hot and cold water faucet handles when they were in the on position. k. Observation on 11/2/16 at 11:55 AM of the sink in room 15 revealed water leaked from beneath the hot water faucet handle when it was in the on position. 3. Concerns identified on the South hall: a. Observation on 11/2/16 at 10:20 AM of room 31 revealed water leaked from beneath the hot water faucet handle when it was in the on position. In addition, the radiator was covered in dirt and debris. b. Observation on 11/2/16 at 10:30 AM of room 32 revealed a 5 inch crack in the top wooden dresser drawer which created sharp uneven edges. In addition, water leaked from beneath the hot and cold water faucet handles when they were in the on position. c. Observation on 11/2/16 at 10:35 AM of room 33 revealed the bathroom radiator was covered in dirt and debris. In addition, there was an 8 inch crack in the linoleum behind the sink which created a surface that was not cleanable. 4. Concerns identified on the East hall: a. Observation on 11/2/16 at 12:15 PM of room 7 revealed the mopboard had peeled away from the bathroom wall which created a surface that was not cleanable. b. Observation on 11/2/16 at 12:20 PM of room 12 revealed a radiator covered in dirt and debris.	F 253	F253 Cont'd: Identification of others: Maintenance Director and/or Housekeeping Supervisor and/or design will conduct audits relating to the observed findings throughout the facility. Any such observations will be repaired, replaced and/or cleaned. Systemic Changes: Staff Development Coordinator and/or designee will provide education relating to identifying the repairs, replacement and/or cleaning of such items needed. Education will be provided to staff relating to the system of reporting such observations. Monitoring: Maintenance Director and/or designee will conduct weekly audits relating to the observations for one month and randomly thereafter. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained. F282 Resident #50's care plan was reviewed for appropriate elimination program and staff education provided by Staff Development Coordinator to ensure it is followed.	12-2-16

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F 253	Continued From page 6 6. Concerns identified in the Purple Sage dining room: a. Observation on 11/2/16 at 4:05 PM, and again on 11/3/16 at 9 AM showed the metal weather stripping at the base of the exit door was bent inwards toward the dining area which created a sharp edge. b. Observation on 11/2/16 at 4:05 PM, and again on 11/3/16 at 9 AM showed the floor in front of the exit door had a darkened area of dirt. c. Observation on 11/2/16 at 4:05 PM, and again on 11/3/16 at 9 AM showed the edges of the floor around the perimeter of the room was discolored with a buildup of dirt and debris. 6. Interview with the maintenance supervisor on 11/3/16 at 8:10 AM revealed that he had been the manager since April 2016 and had one PRN (as needed) staff member. A maintenance request book was located at each nurses' station, but he did not have a timeline in place to address the requests. In addition, he verified the identified building concerns were in need of repair.	F 253	F282 Cont'd: Identification of Others: DNS and/or designee will audit Residents with elimination care plans relating to following the elimination care plan. Any residents having elimination care plans not being followed will be toileted per the care plan at that time. Systemic Changes: Staff Development Coordinator will provide education to staff relating to the elimination care plans, residents having such care plan and following such care plans. Monitoring: DNS and/or designee will conduct audits randomly weekly relating to following elimination care plans for one month. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure care was provided in accordance with the written plan of care for 1 of 13 sample residents (#50).	F 282	F283 The Interdisciplinary Discharge Summary for Resident #75 will be completed by the interdisciplinary care team.	12.2.16

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F 282	Continued From page 7 Review of the elimination care plan for resident #50, updated on 10/20/16, indicated s/he had no perception of the need to eliminate or of being soiled. Further review of the care directive form, reviewed 10/17/16, indicated his/her toileting schedule to be: "PRN, before and after meals, & upon rising and before bed." The following concerns were identified: a. Continuous observation of the resident on 11/1/16 from 8:09 AM until 2:05 PM revealed the resident was not offered or provided toileting assistance until 2 PM. At 2 PM CNA #1 and bath aide #1 took the resident to the room and removed the incontinence brief, which was soaked heavily with strong-smelling urine. b. During an interview on 11/2/16 at 9:45 AM CNA #1 stated the resident's care directive included toileting "before and after meals, and as needed." c. Interview on 11/3/16 at 10:40 AM with the DON revealed that the care directive for the resident was correct, and it was her expectation that the staff toilet the resident according to the directive.	F 282	F283 Cont'd: Identification of Others: Interdisciplinary Discharge Summary forms for residents who have discharged from the facility in the last three months will be reviewed for completion. Systemic Changes: DNS and/or designee will provide education to Interdisciplinary team members relating to the discharge summary form. Discharging residents will have a review of the Interdisciplinary Discharge Summary form to ensure completeness. Monitoring: Medical Records Supervisor and/or designee will conduct audits of medical records for each resident who has discharged from the facility relating to the completion of the Interdisciplinary Discharge Summary form. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained. F315 Resident #50's care plan was reviewed for appropriate elimination program and staff education provided by Staff Development Coordinator to ensure it is followed.	12.2.16
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.	F 283		

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F 283	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a discharge summary with a recapitulation of stay for 1 of 1 closed records (#75) with an anticipated discharge. The findings were: Review of the closed medical record revealed resident #75 was discharged on 8/26/16 to an assisted living facility. Further review of the medical record showed the Interdisciplinary Discharge Summary form was not completely filled out; over 50% of the entries were left blank. During an interview on 11/2/16 at 5:30 PM the DON confirmed the discharge summary was incomplete and lacked a full recapitulation of stay.	F 283	Identification of Others: DNS and/or designee will audit Residents with elimination care plans relating to following the elimination care plan. Any residents having elimination care plans not being followed will be toileted per the care plan at that time. Systemic Changes: Staff Development Coordinator will provide education to staff relating to the elimination care plans, residents having such care plan and following such care plans.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure care was provided in a timely manner for 1 of 6 sampled residents (#50) with incontinence. The	F 316	Monitoring: DNS and/or designee will conduct audits randomly weekly relating to following elimination care plans for one month. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained. F329 Physician review requests relating to GDR's for resident #64, resident #18 and resident #25 have been sent to the physician to be completed. Identification of Others:	12-2-16

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F 315	Continued From page 9 findings were: Review of the quarterly MDS assessment dated 6/16/16 showed resident #50 had diagnoses which included advanced dementia with behaviors, muscles weakness, osteoarthritis and a previous fall with injury. The resident was not able to make his/her needs known verbally and was totally dependent on staff for toileting. Review of the elimination care plan for the resident, updated on 10/20/16, indicated s/he had no perception of the need to eliminate or of being soiled. Further review of the care directive form, reviewed 10/17/16, indicated his/her toileting schedule to be: "PRN, before and after meals, & upon rising and before bed." The following concerns were identified: a. Continuous observation on 11/1/16 from 8:09 AM until 2:05 PM revealed the resident was not offered or provided toileting assistance. At 2 PM, CNA #1 and bath aide #1 took the resident to the room and removed the incontinence brief which was soaked heavily with strong-smelling urine. b. During an interview on 11/2/16 at 9:45 AM CNA #1 stated that the resident's care directive included toileting "before and after meals, and as needed." c. Interview on 11/3/16 at 10:40 AM with the DON revealed the care directive for the resident was correct, and it was her expectation that the staff toilet the resident according to the directive.	F 315	F329 Cont'd: Identification of Others: Social Service Director and/or designee will conduct a facility-wide audit to confirm those residents ~~prescribed anti-psychotic~~ drugs receive gradual dose reduction and behavior intervention timely. Systemic Changes: DNS and or designee will provide education to staff relating to the requirement of the physician review of GDR's. Monitoring: Audits shall be conducted by the DNS and/or designee relating to the physician review of GDR's weekly for one month. Results of the audits shall be brought to the quality assurance meeting at least monthly until the correction is sustained. F387 Physicians will be contacted and visits will be scheduled to be completed for resident #18 and resident #26. Identification of Others: Medical Record Supervisor and/or ~~designee will conduct audits of the~~	
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	F 329		

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F 329	Continued From page 10 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 3 of 15 sample residents (#18, #25, #84). The findings were: 1. Review of physician orders for resident #84 showed on 12/30/15 Fluoxetine HCL (antidepressant) 20 mg/5 ml (5 ml) solution once per day was ordered for "other depressive episodes." Further review of the medical record showed no evidence a gradual dose reduction (GDR) had been attempted, nor documentation from the physician to indicate a GDR would be	F 329	F387 Cont'd: medical records relating to timely physician visits. Physician visits will be completed for those residents requiring a visit. Systemic Changes: DNS and/or designee will provide education relating to the timeliness of physician visits and documentation of the visit to staff involved in tracking and scheduling physician visits. Monitoring: Medical Records Supervisor will conduct audits weekly relating to the timeliness of physician visits for one month. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained. F425 Front hall/SCU wound treatment cart and the TV Hall medication cart will be inspected and any observed expired medication will be removed. Those medications were immediately removed upon finding by surveyors. Identification of Others: DNS, Charge Nurses completed and immediate inspection of the other wound treatment cart and other	12/2/16

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F 329	Continued From page 11 contraindicated. 2. Review of physician orders for resident #18 showed on 1/19/16 Venlafaxine (antidepressant) 75 mg once per day was ordered for "depression." Further review of the medical record showed no evidence a GDR had been attempted, nor documentation from the physician to indicate a GDR would be contraindicated. 3. Review of physician orders for resident #25 showed on 12/16/15 Sertraline (antidepressant) 150 mg once per day was ordered for "depression." Further review of the medical record showed no evidence a GDR had been attempted, nor documentation from the physician to indicate a GDR would be contraindicated. 4. During an interview on 11/3/16 at 11:30 AM the DON stated she was unable to find any further documentation related to the lack of GDRs. She further stated there had been a "break in the process" related to GDRs.	F 329	F425 Cont'd; medication carts any observed expired medications were immediately removed. Systemic Changes: Staff Development Coordinator and/or designee will provide education to staff relating to expired medications in treatment and medication carts being removed and not available for residents. Charge Nurses and Central Supply will complete inspection relating to expired medications each week. Inspection logs will be reviewed by the DNS. Monitoring: DNS and/or designee will conduct audits of treatment and medication carts inspections weekly for one month. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained.	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT 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:	F 387	F431 1. The Novolog Insulin 10 ml vial for use of Resident #63 was removed from the Front hall medication cart. 2. The following medications were removed from the TV Hall medication cart:	12-2-16

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F 387	Continued From page 12 Based on medical record review and staff interview, the facility failed to ensure physician visits were completed at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for 2 of 9 sample residents (#18, #26). The findings were: 1. Review of the medical record for resident #18 showed the resident was admitted to the facility on 1/19/16. Review of the "Progress Notes" showed physician visits were completed on 2/11/16, 4/12/16, and 6/16/16. Further review showed there were no additional visits from 2/11/15 through 4/12/16 (61 days). In addition, there were no documented physician visits after 6/16/16 for the resident. Interview with the DON on 11/3/16 at 11:33 AM confirmed the facility could produce no evidence of completed physician visits. 2. Review of the medical record for resident #26 showed the resident was admitted to the facility on 8/8/16. Review of the entire medical record showed no evidence of any physician visits after admission. Interview with the DON on 11/3/16 at 8:07 AM confirmed physician visits were not completed.	F 387		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F431 Cont'd: a. Levimir Flextouch insulin pen with no label; b. The box of Albuterol/Ipartroium nebulizer solution (63)vials with no label; Identification of Others: DNS, Charge Nurses completed and immediate inspection of the other wound treatment cart and other medication carts any observed expired medications were immediately removed. Systemic Changes: Staff Development Coordinator and/or designee will provide education to staff relating to expired medications in treatment and medication carts being removed and not available for residents. Charge Nurses and Central Supply will complete inspection relating to expired medications each week. Inspection logs will be reviewed by the DNS. Monitoring: DNS and/or designee will conduct audits of treatment and medication carts inspections weekly for one month. Results of the audits will be brought to the quality assurance	

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F 425	Continued From page 13 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure expired medications were not available for use in 2 of 6 medication/treatment carts (Front hall/SCU treatment cart and TV hall medication cart). The findings were: 1. Observation of the Front hall/SCU wound treatment cart on 11/3/16 at 9:30 AM showed five "Woun'Dres" (collagen hydrogel wound dressing) tubes that were expired. One tube had an expiration date of 03/16, three tubes had an expiration date of 04/16, and one tube had an expiration date of 08/16. Interview at that time with LPN #1 verified the medication was available for resident use and past the expiration date. 2. During observation of the TV hall medication cart on 11/3/16 at 9:55 AM the following concerns were identified: a. One bottle of Citracal (calcium supplement) had an expiration date of 05/14. b. One bottle of Calcium with vitamin D had	F 425	F431 Cont'd: meeting at least monthly until the correction is sustained.	

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F 425	Continued From page 14 an expiration date of 07/16. c. One bottle of Glucosamine Sulfate (arthritis medication) 1000 mg had an expiration date of 06/16. d. Interview at that time with LPN #2 verified the medications were available for resident use and past the expiration date. 3. Interview with Central Supply clerk #1 on 11/3/16 at 10:13 AM revealed the treatment carts were checked and re-stocked every Friday. In addition, he stated medication carts were stocked when they were low and the nurses gave him a list of what was needed. 4. Review of the policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles", revised 01/01/13, showed "...4. Facility should ensure that medications and biologicals:...4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines...16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications...". 5. Review of the policy titled, "Over the Counter (OTC) Medications", dated April 2015, showed ..."The Center disposes of contaminated or expired OTC medications...".	F 425		
F 431 SS=D	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 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	F 431		

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F 431	Continued From page 15 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, staff interview, review of manufacturer's instructions, and policy and procedure review, the facility failed to ensure medications were labeled with the expiration date once opened in 2 of 6 medication/treatment carts (Front hall medication cart and TV hall medication cart). In addition, the facility failed to ensure proper resident identification on medications. The findings were:	F 431		

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F 431	Continued From page 16 1. Observation of the Front hall medication cart on 11/3/16 at 9:55 AM showed one Novolog Insulin 10 ml vial, open and available for use, for resident #63 was not labeled with the date opened or the expiration date. Review of the manufacturer's instructions showed Novolog expired 28 days after opening. 2. During observation of the TV hall medication cart on 11/3/16 at 9:55 AM the following concerns were identified: a. One Levimir Flextouch insulin pen, open and available for use, was not labeled with an open or expiration date. In addition, there was no pharmacy label on the pen to identify which resident the pen belonged to. Review of the manufacturer's instructions showed Levimir expired 42 days after opening. b. One box of Albuterol/Ipratropium (asthma medication) nebulizer solution (62 vials), open and available for use, did not have a pharmacy label on the box to identify which resident the vials belonged to. c. Interview at that time with LPN #2 confirmed she was unsure which resident the medications belonged to and she verified that insulin vials should be labeled with the resident's name and either an open or expiration date. In addition, she stated "typically the Albuterol/Ipratropium boxes should be in a sealable bag with the resident's pharmacy label on it." 3. Review of the policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles", revised 01/01/13, showed "...5. Once any medication or biological package is	F 431		

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F 431	Continued From page 17 opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date...". 4. Interview with the DON on 11/3/16 at 11:33 AM confirmed that insulin should be labeled with an open date and her expectation was for the nurses to be doing so.	F 431		