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

PRINTED: 02/09/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	01/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 1/23/17 through 1/26/17. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set PRN: Pro renata (as needed) RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 156	The facility will ensure that required notices are posted in a form and manner accessible to residents and resident representatives by: AB) Information regarding how to contact the Ombudsman, file a complaint, and resident rights will be posted in a common area at a height accessible to all residents. C) DON or designee will educate licensed and unlicensed staff on the location of this information so they may assist in directing residents and their representatives to it as appropriate. D) MSS will discuss this information with each resident or their representative. E) A tool will be implemented to monitor that requried notices are displayed appropriately. This will be completed monthly	3/10/2017

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

Brenda Gorm, RN | DON | 2-22-17

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.

RECEIVED
FEB 22 2017
Healthcare Licensing and Surveys

The plan of correction was accepted on 2/22/17 at 2:25pm. Brenda Gorm, DON, was notified. The DOC is 3/10/17
Jean Hunn

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F 156	Continued From page 1 (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State	F 156	Continued From page 1 and reported quarterly to the PI committe. The DON is responsible for compliance.	

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F 156	Continued From page 2 and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(il) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for	F 156		

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F 156	Continued From page 3 information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon	F 156		

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F 156	Continued From page 4 admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident	F 156		

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F 156	Continued From page 5 before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (I) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 156		

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F 156	Continued From page 6 Based on observation, resident interview, and staff interview the facility failed to post the required notices in a form and manner accessible to residents and resident representatives. The findings were: 1. Observation of a bulletin board in the common area on the first floor of the facility showed a 3 foot long by 5 foot wide enclosed information board. The bottom of the board was 4 feet off the floor and the top was 7 feet off the floor. The board contained the required information, however, it was displayed in a manner not easily seen or read by the residents. 2. Interview with a group of 9 residents on 1/24/17 at 10:45 AM revealed 7 of the 9 residents did not know how to contact the ombudsmen, file a complaint, or where the list of resident rights was located. 3. Interview with the DON on 1/25/17 at 4:25 PM confirmed the information was not presented in a manner that was readily accessible to the residents.	F 156		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 157	The facility will notify resident representives of changes of conditions with hospitalizations by: A) Resident #40, representative was contacted and updated on resident's condition. B) The facility will do an audit of all residents who have been admittted to the hospital or visited ER in the last quarter to determine if notification was approrpiate. C) DON or designee will educate all LPN's and RN's of the requirement to contact a	3/10/2017

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F 157	Continued From page 7 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 157	Continued From page 7 resident's representative when a resident visits the ER or is hospitalized. If an alert and oriented resident declines to have their representative notified of an ERvisit, the nurse will clearly document this in the resident's chart. D) A tool will be implemented to ensure resident representatives are notified appropriately. This will be completed monthly and reported quarterly to the PI committee. DON is responsible for compliance.	

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F 157	Continued From page 8 and staff interview the facility failed to notify the resident's representative of a change of condition of 1 of 2 sample residents (#40) with hospitalizations. The findings were: 1. Observation on 1/23/17 at 5:29 PM showed resident #40 was seated in the dining room with a plate of uneaten food in front of him/her. The resident was sweating, twitching, and combative. CNA #1 notified RN #1 of the situation. The RN asked for a glucometer and then transferred the resident from the dining room chair into a wheelchair and removed the resident from the dining area. The resident's glucose level at this time measured 22 mg/dL (milligrams/deciliter). The resident was given a glucose gel orally and was taken to the emergency department. 2. Review of the medical record showed the resident's representative was to be notified if the resident had to go to the emergency room or if a doctor was involved. Further review showed no evidence the resident's representative was notified of the 1/23/17 emergency room visit. 3. Interview with the team leader #1 on 1/26/17 at 8:55 AM confirmed the resident's representative had not been notified.	F 157		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the	F 166	The facility will ensure that residents are aware of their right to file grievances by: AB) MSS will discuss the right to file grievances with each resident or their representatvie and the process of filing grievances. C) The greivance policy will be update to include all necessary information. DON or designee will educate staff on the grievance process as they may direct	3/10/2017

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F 166	Continued From page 9	F 166	Continued From page 9	

resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

Continued From page 9

residents and their representatives as appropriate.
D) A tool will be implemented to ensure residents are aware of their rights to file a grievance. This will be completed monthly and reported quarterly to the PI committee. DON is responsible for compliance.

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F 166	Continued From page 10 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 166		

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F 166	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of policy and procedure the facility failed to ensure residents were aware of their right to file grievances. The census was 40. The findings were: 1. Observation of the facility showed no evidence information about the facility's grievance policy and procedures was posted in any resident areas. 2. Interview with a group of 9 residents on 1/24/17 at 10:45 AM revealed 7 of the 9 residents did not know how to file a grievance or complaint. 3. Review of the Policy and Procedure entitled "Complaints and Grievances," last updated January 2017, did not address the process on how to file a grievance anonymously, did not contain contact information for the grievance official, and did not specify a reasonable expected time frame for completion of the grievance review. 4. Interview with the DON on 1/25/17 at 4:16 PM revealed she was the grievance officer for the facility. She confirmed information about the procedure for filing complaints or grievances was not posted in any resident areas. Further, it was revealed the process for filing grievances was for residents to go to the DON if they had a grievance and she completed the grievance/complaint form.	F 166		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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

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F 226	Continued From page 12 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on employee file review and staff interview the facility failed to ensure training related to abuse, neglect, and misappropriation of resident property was provided for 2 of 2 employees (housekeeper #1, dietary aide #1)	F 226	The facility will ensure staff are trained related to abuse, neglect,and misappropriation of resident property prior to contact with residents by: A) Housekeeper #1 and dietary aide #1 were trained on 2-2-2017 in regard to abuse, neglect, and misappropriation of residents property. B) An audit will be completed of all employees hired in the last quarter to determine if furtheer training is needed. The new employee process was updated in January 2017 to include training in regards to abuse, neglect, and misappropriation of resident property. All new employees are trained in these areas prior to working with residents. C) Director of Administration will educate HR, AHCC DON, and Director of Environmental Services of the need for all staff to be trained on abuse, neglect, and misappropriation of resident's property prior to scheduling them to work in AHCC. D) A tool will be implemented that all new employees are appropraitely trained on abuse, neglect, and misappropriateion of resident property prior. This will be completed monthly and reported to the PI committee. The Director of Administration is responsible for compliance.	3/10/2017

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F 226	Continued From page 13 reviewed. The findings were: 1. Review of the employee file for housekeeper #1 showed no evidence of training in regard to abuse, neglect, and misappropriation of resident property. 2. Review of the employee file for dietary aide #1 showed no evidence of training in regard to abuse, neglect, and misappropriation of resident property. 3. Interview with the DON on 1/25/17 at 4:25 PM revealed training was not done for new hires on abuse, neglect, and misappropriation of resident property prior to resident contact. Nursing staff were required to sign the abuse policy, but dietary and housekeeping were not given any training. 4. Interview with the social service director on 1/26/17 at 8:27 AM confirmed training on abuse, neglect, and misappropriation of resident property was not done during orientation of new employees.	F 226		
F 279 SS=E	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279	The facility will ensure care plans are developed to include measurable objectives and individualize approaches by: A) Resident #15 care plan was updated to reflect symptoms and behaviors to monitor related to use of psychotropic medications. Resident #23 care plan was updated to reflect instructions to achieve nectar thick consistency liquids; interventions for seizure precautions; and this diagnosis of atrial fibrillation, treatment and potential medication side effects for apixaban. Resident #28 care plan was updated to	3/10/2017

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F 279	Continued From page 14 (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 279	Continued From page 14 include psychotropic drug use medications and side effects; activity types and goals; defined weight gain/loss amounts; and goals for ADL function. Resident #29 care plan was updated to reflect symptoms and behaviors related to depression to monitor related to medication use. B) All residents could be affected by incomplete care plans. Team leaders for each floor will audit all care plans to ensure they are complete. Team leaders will utilize a checklist and review each other's quarterly care plans weekly. If omissions are identified, this will immediately be brought to the attention of the other team leader for correction. C) Nurse team leaders will receive training on care plans, developing measureable objectives and individualized approaches so residents attain or maintain the resident's highest practicable physical, mental, and psychosoical well-being. This training may be done online, webexes, books/paper, and other training that is available. DON is responsible for compliance. D)A tool will be implemented to ensure care plans are developed to include measurable objectives and individualized approaches. This will be completed monthly and reported quarterly to the PI committee. Team Leaders are responsible for compliance.	

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F 279	Continued From page 15 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure care plans were developed to include measurable objectives and individualized approaches for 4 of 10 sample residents (#15, #23, #28, #29). The findings were: 1. Review of the 12/7/16 quarterly MDS assessment showed resident #28 had diagnoses which included non-Alzheimer's dementia and anxiety disorder. Review of the medication record showed the resident had a physician's order for Xanax (anti-anxiety) 0.25 mg (milligrams) twice a day and Celexa (anti-depressant) 20 mg daily with a start date of 8/15/16. Review of the 8/25/16 admission MDS assessment showed the resident had triggered for further assessment in areas that included Psychotropic Drug Use, ADL Function, Dehydration Fluid Maintenance, and Activities. Review of the CAAs for these areas revealed a decision to develop a care plan. The following concerns were identified related to the development of care plans: a. Review of the care plan for "Psychotropic Drug Use" dated 10/11/16 showed there were blanks throughout the care plan. These included areas where specific medications were to be shown, where side effects were to be listed, and where dates or outcome of screenings related to possible side effects of the medication use (such	F 279		

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F 279	Continued From page 16 as falls and tardive dyskinesia) were to be completed. b. Review of the care plan for "Activities" dated 10/11/16 showed there were blanks throughout the care plan. These included the goal areas of how often, when, and what kind of activities the resident would be encouraged to attend. c. Review of the care plan for "Dehydration/Fluid Maintenance" dated 10/11/16 showed the goal was related to ensuring the resident's weight gain/loss. The area to define the specific weight amounts was blank and had not been completed. d. Review of the care plan for "ADL Function Care Deficit" dated 10/11/16 showed Goals; "....4) Res [resident] will continue to perform hygiene with [left blank] assist thru next qtr [quarter]." 2. Review of the 11/24/16 quarterly MDS assessment showed resident #15 had diagnoses which included anxiety, had a BIMS score of 14, and had a depression severity score of 15 (moderately severe depression). Review of the electronic medical record on 1/24/17 showed the resident had an order for Celexa (anti-depressant) 10 mg once daily which was ordered on 11/30/16, Seroquel (anti-psychotic) 25 mg once daily at bedtime which was ordered on 5/11/16, and lorazepam (anti-anxiety) 0.5 mg twice daily as needed. The following concerns were identified: a. Review of the "Psychotropic Drug" care plan, last modified on 1/25/17, showed the facility was to "evaluate medication dosage and frequency" and "make recommendations for decreasing" the medication; however, there were no symptoms or behaviors identified for the facility to monitor related to the medication use.	F 279		

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F 279	Continued From page 17 b. Review of the "Mood State" care plan, last modified on 1/25/17, showed the resident had depression and social isolation; however, there were no symptoms or behaviors identified for the facility to monitor related to the medication use. 3. Review of the 11/28/16 quarterly MDS assessment showed resident #29 had diagnoses which included depression and had a depression severity score of 0 (minimal). Review of the electronic medical record on 1/24/17 showed the resident had an order for Prozac (anti-depressant) 20 mg once daily which was ordered on 8/1/16. The following concerns were identified: a. Review of the "Psychotropic Drug" care plan, last modified on 1/2/17, showed there were no identified symptoms or behaviors related to depression for the facility to monitor related to the medication use. 4. Review of the 11/22/16 quarterly MDS assessment showed resident #23 had diagnoses which included hypertension, seizure disorder, congestive obstructive pulmonary disease, and idiopathic normal pressure hydrocephalus with cerebrospinal fluid device, and gout. The following concerns were identified: a. Review of the "Medac [computerized system that provides resident care needs]" showed the resident was placed on thickened liquids with nectar consistency on 5/12/16, however, the nutritional status section of the resident's care plan did not reflect the instructions to achieve nectar thick consistency. b. Review of the "Medac" showed the resident had instructions for "seizure precautions," however, the resident's care plan did not define interventions for the "seizure	F 279		

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F 279	Continued From page 18 precautions." Further, interview with RN #3 on 1/24/17 at 8:40 AM revealed the facility did not have a specific protocol or policy on seizure precautions. The RN stated, "I suppose we would just check on [him/her] more often." c. Interview with team leader #1 on 1/23/17 during the initial tour which began at 3:05 PM revealed the resident had been admitted to the emergency room on 1/5/17 following a seizure episode. Upon return to the facility, the resident had a new diagnosis of atrial fibrillation and was placed on apixaban (anti-coagulant) 2.5 mg twice daily. Review of the care plan, last modified on 1/12/16, showed no evidence the new diagnosis, treatment, or potential medication side-effects had been identified. 5. Interview with team leader #1 on 1/26/17 at 8:55 AM confirmed the care plans lacked details and were incomplete. 6. Interview with the team leader #1 and team leader #2 on 1/26/17 at 11:50 AM revealed the facility used a standardized care plan and tried to individualize it. Further, it was confirmed the care plans did not contain all the information required to care for residents because some was on the "Medac" system. 7. Interview with the DON on 1/26/17 at 11:03 AM revealed the facility only monitored psychotropic medications and behaviors when there was a change in the medication and the facility did not have a routine monitoring system for behaviors.	F 279		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life	F 309	The facility will ensure that medication is administered according to physician orders for residents receiving insulin by:	3/10/2017

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F 309	Continued From page 19 Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview,and medical record review, the facility failed to ensure medication was administered according to physician orders for 1 of 4 sample residents (#40) who received insulin. This failure resulted an incident of hypoglycemia requiring emergency treatment at the hospital for resident #40. The findings were: 1. Observation on 1/23/17 at 5:29 PM showed resident #40 was seated in the dining room with a plate of uneaten food in front of him/her. The resident was sweating, twitching, and combative. CNA #1 notified RN #1 of the situation. The RN	F 309	Continued From page 19 A) Resident #40 insulin will be given according to the parameters ordered by his/her physician. B) All residents receiving insulin could be affected. The team leader for each floor will keep a daily written monitor of residents who receive insulin based on blood glucose levels. The team leader will record blood glucose values used to determine insulin usage and whether or not insulin was given or held appropriately according to physicians orders. If insulin is not given or held appropriately, the team leader will intervene, notify the DON and initiate a medication error report. C) The DON will provide education to all nursing staff on each resident's insulin orders and the parameters established by the physicians. D) A tool will be implemented to ensure insulin is administered according to physician orders. This will be completed monthly and reported to quarterly to the PI committee. DON is responsible for compliance.	

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F 309	Continued From page 20 asked for a glucometer and orange juice and then transferred the resident from the dining room chair into a wheelchair and removed the resident from the dining area. The resident's glucose level at that time was measured at 22 mg/dL (milligrams/deciliter). The resident was given a glucose gel orally and was taken to the emergency department (ER). 2. Review of the Emergency Room Note dated 1/23/17 showed the resident's blood glucose was measured at 23 mg/dL upon arrival at the hospital. 3. Review of a physician order dated 11/16/16 showed an order for 3 units of NovoLOG (short-acting insulin) 100 units/ml be injected SQ (subcutaneous) three times a day with meals. In addition the order stated "do not give if the BS (blood sugar) is less than 120." The following concerns were identified: a. Review of the medication record revealed the resident's blood sugar was measured at 83 mg/dL on 1/23/17 at 4:40 PM, and 3 units of NovoLOG was administered to the resident at that time. b. Review of the medication record showed between 11/30/16 and 1/23/17 NovoLOG was administered 7 times when the resident's blood sugar measured between 100 mg/dL and 120 mg/dL. Further, NovoLOG was administered 5 times when the blood sugar was below 100 mg/dL. 4. Interview with the resident on 1/25/17 at 4:50 PM revealed that s/he had not been aware of the drop in his/her blood sugar on 1/23/17 when s/he had to go to the ER. In addition, s/he stated that s/he knew his/her blood sugar was too low (83	F 309		

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F 309	Continued From page 21 mg/dL) to receive the insulin and s/he knew it was too soon before dinner for the insulin to be administered, but "s/he figured the nurse knew what she was doing." 5. Interview with the DON on 1/25/17 at 11:25 AM revealed the nurse should not have administered the medication when the blood glucose was below 120 mg/dL. Further, each time the medication was administered outside the physician's parameters, a medication variance should have been completed and it was confirmed medication variances were not completed. 6. Interview with the DON and team leader #1 on 1/25/17 at 12:20 PM revealed the computer system did not provide a prompt or notification for the nurse not to administer the medication if the blood glucose was below the parameters for administration.	F 309		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329	The facility will ensure behavior monitoring is complete for residents with physician's orders for psychotropic medications. The facility will document the necessity and effectiveness of as needed medication. This will be accomplished by: A) CNAs and/or nursing staff will monitor residents #11, 15, 24, 28, 29 and 40 daily for behaviors which relate to their psychotropic medication use. A) Nursing staff and medication aides will document necessity and effectiveness of as needed medication for residents #23, 24, 28 and 40. B) All residents receiving psychotropic medication could be affected by lack of behavior monitoring. All such residents	3/10/2017

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F 329	Continued From page 22 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure behavior monitoring was completed for 6 of 6 sample residents (#11, #15, #24, #28, #29, #40) with physician's orders for psychotropic medications and failed to document necessity and effectiveness for 4 of 9 sample resident (#23, #24, #28, #40) receiving as needed medications. The findings were: 1. Review of the 1/4/17 quarterly MDS assessment showed resident #11 had diagnoses which included depression and "mental disorder," had a BIMS score of 7, and had a depression severity score of 12 (moderate depression). Review of the electronic medical record on 1/24/17 showed the resident had an order for Zoloft (anti-depressant) 100 mg daily at bedtime which was ordered on 6/15/16 and Haldol (anti-psychotic) 0.5 mg tablet every other day alternating with 0.25 mg tablet every other day. Review of the "psychosocial well-being" care plan, last modified on 1/2/17, showed the facility would evaluate effectiveness and side effects of Zoloft and Haldol for possible reduction and/or discontinuation. Review of the "psychotropic drug use" care plan, last modified on 1/2/17, showed the facility would administer, observe, and monitor for desired and adverse effects of medications, report to the physician, and decrease dosage appropriately. Review of the	F 329	Continued From page 22 will have a paper monitor prepared where CNAs and/or nursing staff will monitor individual behaviors on a daily basis. Nurse team leaders will summarize this information for residents' primary physicians to review on rounds. Team leaders will check documentation on all involved residents three times per week. If documentation is not completed, the team leader will provide immediate inservicing. B) All residents receiving as needed medications could be affected by lack of documentation for neccessity and effectiveness. A nurse or medication aide will document the required information in the resident's legal record. DON will randomly check various residents records (at least six per week), and various nurses and medication aides to ensure documentation is appropriate. If documentation is not complete, immediate inservicing will be provided. C) DON or designee will educate all nursing staff and CNAs on how to monitor behaviors for residents with psychotropic drug use. C) DON or designee will provide education to all nursing staff and medication aides reviewing the need to document necessity and effectiveness of as needed medications. D) A tool will be implemented to ensure behavior monitoring is complete for residents with physician orders for psychotropic medications. This will be completed monthly and reported quarterly	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	01/26/2017

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

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F 329	Continued From page 23 "behavior" care plan, last modified on 1/2/17, showed the resident had delusions, picking at skin, and insect psychosis. The following concerns were identified: a. Review of the medical record showed no evidence the facility was monitoring for side effects or tracking resident specific behaviors to evaluate the effectiveness of the medications. 2. Review of the 11/24/16 quarterly MDS assessment showed resident #15 had diagnoses which included anxiety, had a BIMS score of 14, and had a depression severity score of 15 (moderately-severe depression). Review of the electronic medical record on 1/24/17 showed the resident had an order for Celexa (anti-depressant) 10 mg daily which was ordered on 11/30/16, Seroquel (anti-psychotic) 25 mg daily at bedtime which was ordered on 5/11/16, and lorazepam (anti-anxiety) 0.5 mg twice daily as needed. The following concerns were identified: a. Review of the "psychotropic drug" care plan, last modified on 1/25/17, showed the facility was to "evaluate medication dosage and frequency" and "make recommendations for decreasing" the medication; however, there were no symptoms or behaviors identified for the facility to monitor related to the medication use. b. Review of the "mood state" care plan, last modified on 1/25/17, showed the resident had depression and social isolation; however, there were no symptoms or behaviors identified for the facility to monitor related to the medication use. c. Review of the medical record showed no evidence the facility was monitoring for side effects or tracking resident specific behaviors to evaluate the effectiveness of the medications.	F 329	Continued From page 23 to the PI Committee. Nurse team leaders will be responsible for compliance. D) A tool will be implemented to ensure necessity and effectivenerss of as needed medication is documented appropriatedly. This will be completed monthly and reporterd quarterly to the PI Committee. DON is responsible for compliance.	

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F 329	Continued From page 24 3. Review of the 11/28/16 quarterly MDS assessment showed resident #29 had diagnoses which included depression, had a BIMS score of 13, and had a depression severity score of 0 (minimal). Review of the electronic medical record on 1/24/17 showed the resident had an order for Prozac (anti-depressant) 20 mg daily which was ordered on 8/1/16. The following concerns were identified: a. Review of the "psychotropic drug" care plan, last modified on 1/2/17, showed there were no identified symptoms or behaviors related to depression for the facility to monitor. b. Review of the medical record showed no evidence the facility was monitoring for side effects or tracking resident specific behaviors to evaluate the effectiveness of the medications. 4. Review of the 12/7/16 quarterly MDS assessment showed resident #28 had diagnoses which included non-Alzheimer's dementia and anxiety disorder. Review of the medication record showed the physician ordered medication which included Xanax (anti-anxiety) 0.25 mg (milligrams) twice a day and Celexa (anti-depressant) 20 mg daily. Further the resident had an order for hydrocodone/acetaminophen (pain medication) 5/325 mg PRN every 4-6 hours. The following concerns were identified: a. Review of the medical record showed no evidence the facility was monitoring signs or symptoms of side effects or tracking resident specific behaviors to evaluate the effectiveness of the psychotropic medications. b. Review of the MAR showed 38 doses of the hydrocodone/acetaminophen had been administered between 12/14/16 and 1/24/17. Review of the PRN Flowsheet for dates between	F 329		

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F 329	Continued From page 25 12/10/16 and 1/23/17 showed 24 of the 38 doses administered had no documentation related to the resident's pain intensity, nonpharmaceutical interventions attempted, or the effectiveness of the medication. 5. Review of the 11/10/16 admission MDS assessment showed resident #40 had diagnoses which included depression. Review of the medication record showed the physician ordered medication which included Wellbutrin (anti-depressant) 75 mg twice a day and Celexa 40 mg daily. Further the resident had an order for hydrocodone/acetaminophen 5/325 mg PRN every 4-6 hours. The following concerns were identified: a. Review of the medical record showed no evidence the facility was monitoring signs or symptoms of side effects or tracking resident specific behaviors to evaluate the effectiveness of the psychotropic medications. b. Review of the MAR showed 33 doses of the medication had been administered between 11/10/16 and 1/23/17. Review of the PRN Flowsheet for dates between 1/18/17 and 1/23/17 showed only 4 of the 6 doses administered had the appropriate documentation related to pain intensity, nonpharmaceutical interventions, and effectiveness. 6. Review of the 12/11/16 quarterly MDS assessment showed resident #24 had diagnoses which included hip fracture, non-Alzheimer's dementia, atrial fibrillation, dementia with behavior disturbance, fracture of left femur, fracture of head of right femur, and dorsalgia (back pain). Review of the medication record showed the physician ordered medication which included haloperidol (anti-psychotic) 1 mg tablet	F 329		

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F 329	Continued From page 26 twice a day and lorazepam (anti-anxiety) 1 mg tablet every 4-6 hours as needed. Further, the resident had an order for hydrocodone/acetaminophen 5/325 mg ordered three times daily and PRN for pain. The following concerns were identified: a. Review of the medical record showed no evidence of behavior or side effect monitoring related to the use of psycho-active medications. b. Review of the medication record for dates between 1/11/17 and 1/25/17 showed the resident received a PRN dose of the medication 2 times, but documentation failed to show the reason the medication was given, or the effectiveness on the PRN flowsheet. 7. Review of the 11/22/16 quarterly MDS assessment showed resident #23 had diagnoses of hypertension, non-Alzheimer's dementia, seizure disorder, normal pressure hydrocephalus (a type of brain malfunction with typical symptoms of urinary incontinence, dementia, and gait disturbance), and gout. Review of the medication record showed the resident had an order for oxycodone IR 5 mg tablet twice daily and PRN every 6-8 hours for pain. The following concerns were identified: a. Review of the medication record for dates between 1/11/17 and 1/25/17 showed the resident received a PRN dose of the medication 11 times, however documentation failed to show the reason the medication was given, or the medication effectiveness on the PRN flowsheet for 10 of the 11 doses administered. 8. Interview with team leader #1 on 1/26/17 at 8:55 AM revealed behavior monitoring for psychoactive drugs was not done.	F 329		

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F 329	Continued From page 27 9. Interview with the DON on 1/26/17 at 9:55 AM revealed the facility relied on their incident reports to monitor behaviors and it was "taken for granted because we are a small facility." 10. Interview on 1/26/17 at 11:03 AM with the DON and team leader #1 revealed nurses were expected to document the necessity of giving PRN medications. Further, it was stated that monitoring for psychotropic medications was done "for several shifts" after starting a medication but was not ongoing.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage,	F 371	The facility will ensure that all opened refrigerated foods are clearly marked and to indicate the date or day when opened and discarded if not consumed within 7 days by; A) The outdated juices and miracle whip in the refrigerators were removed and disposed of. B) The Dietary Manager and reviewed by the Registered Dietitian conducted a check of the kitchen area and refrigerators for areas of noncompliance and corrective action was done immediately. C) A daily kitchen review checklist has been updated to include the checking for proper labeling/dating and for any out of date items. D) The Dietary Manager will educate the Dietary staff on the process, as well as the proper labeling and dating of product including discard dates and storage guidelines. E) The Dietary Manager will monitor the sanitation and safety checklist that includes the daily monitoring and proper	3/10/2017

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F 371	Continued From page 28 handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the policy and procedure, the facility failed to ensure expired items were not accessible for resident consumption in 2 of 3 kitchen refrigerators. The findings were: 1. Observation of the "Traulsen" refrigerator located near the steam table on 1/23/17 at 4:17 PM showed a reusable container labeled "miracle whip" that was dated 1/15/17. 2. Observation of the "Delfield 600XL" refrigerator on 1/26/17 at 7:15 AM showed a box of orange juice dated 12/13/16, a box of pineapple juice dated 1/6/17, nectar-thick cranberry juice dated 1/17/17, and a box of nectar-thick orange juice dated 1/17/17. Further observation showed the boxes were open and in use. 3. Interview with the dietary manager on 1/26/17 at 7:15 AM revealed items in refrigerators were to be dated with the date they were received and the date they were opened. Further, items should be discarded after 7 days and the items identified in the refrigerators should have been removed. 4. Review of the "Protocol Refrigerator" dated 12/19/16 showed "...1. MARK ALL ITEMS WITH DATE WHEN OPENED. Mark out dietary's date and put OPEN after yours...b. Boxed juices discard 7 days after opening..." 5. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR	F 371	Continued From page 28 label, dating and storing of products, including the checking of the refrigerators for undated, or past dated products. The Dietitian or designee will do a kitchen inspection weekly for one month, then twice per month until resolved. F) The Dietary Manager will conduct a report to be given at the QAPI meeting for review and corrective actions taken where necessary until resolved.	

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F 371	Continued From page 29 SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days."	F 371		