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

PRINTED: 03/16/2017
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
	535053	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY LEGACY HOME	100 19TH ST WHEATLAND, WY 82201

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 2/27/17 through 3/2/17. Also reviewed in the course of this survey was complaint intake WY000002357. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse SSD: Social Services Director Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 166 SS=B	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 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	F 166		

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

Administrator 4/6/17

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.

POC accepted on 4/6/2017. The DOC is 4/16/17. NHA, Shane Filipi was notified on 4/6/2017 2:50pm — message left on voice mail

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F 166	Continued From page 1 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; (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	F 166	F166- The grievance poster will be updated to contain all required information including the grievance officials name, address, and phone number and the right to file a grievance anonymously by 3/24/17. All grievance procedure posters will be audited by Social Services or designee using an audit tool, to ensure grievance posters contains all the required information by 4/10/17. Social Services or designee will monitor the grievance procedure sign quarterly, for one year to ensure that it contains all required information. All results will be taken to QA&A for further review and analysis for one year.	4/16/17

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F 166	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedure the facility failed to ensure the grievance policy and procedure contained all required information. The census was 46. The findings were: Observation of the facility showed an 8 by 11 inch framed document located near the entrance to the activity room which explained the procedure	F 166		

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F 166	Continued From page 3 for filing a grievance, however, the document did not contain all required information. The policy did not contain the name, address, or phone number of the grievance official and did not address the right to file a grievance anonymously. Interview with the SSD on 3/2/17 at 8:05 AM confirmed the policy and procedure did not contain the necessary information.	F 166	F274- The current assistance requirements as well as the current plan of care have been reviewed for resident #2 and a significant change is not indicated at this time. A significant change assessment is appropriate for resident #22 and will be completed by April 16, 2017. Floor staff was educated on 3/16/17 regarding changes in condition. Floor staff will inform the care plan team of any resident they feel may meet significant change criteria. The care plan team will evaluate these residents and complete significant changes as indicated. MDS Coordinator or designee will compare resident's status to the most recent comprehensive assessment and subsequent quarterly assessments using an audit tool to determine if a significant change has occurred requiring a significant change in the MDS. The MDS Coordinator has completed the RAC certification course on January 20, 2017. The MDS coordinator has re-reviewed CMS's RAI version 3.0 manual on significant change in status assessment including "acute" conditions that may require a	4/16/17
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, policy and procedure review, and review of the CMS RAI (resident assessment instrument) version 3.0 manual, the facility failed to ensure a significant change assessment was completed for 2 of 7 sample residents (#2, #22) with a significant change. The findings were: 1. Review of the 1/30/17 quarterly MDS assessment showed resident #2 had diagnoses which included schizophrenia, left fibula fracture, and joint disorder. Further, the resident was	F 274		

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F 274	Continued From page 4 independent with transfers and walking in room and corridor; was independent and required set up help for locomotion in and out of the room; supervision with set up help for bed mobility required; and limited assistance of 1 person for dressing, toilet use, and personal hygiene. The following concerns were identified: a. Review of a physician's note dated 10/10/16 showed the resident had a fall "3-4 weeks ago" in his/her room and "twisted [his/her] left ankle." The resident had pain with rotation of the ankle and slight swelling. Review of the assessment/plan section addendum dated 10/12/16 showed results of an x-ray indicated a left non-displaced oblique fibula fracture. b. Review of the 11/1/16 annual MDS assessment showed that after the fall the resident required limited assistance of 1 person for bed mobility, transfers, walking in room, and locomotion on the unit. Further, the resident required extensive assistance of 1 person for dressing, toilet use, and personal hygiene. c. Review of the 8/2/16 quarterly MDS assessment showed that before the fall the resident was independent and required no assistance with bed mobility, transfer, walk in and out of room, and locomotion on and off the unit. Further, the resident required limited assistance of 1 person for dressing, toilet use, and personal hygiene. d. Interview with the DON and MDS coordinator on 3/1/17 at 4:40 PM revealed the resident had a fall that resulted in a fracture. The interview confirmed when the facility identified the fracture and the resident's care needs changed, a significant change assessment should have been completed. Continued interview confirmed a significant change assessment should have also been completed when the fracture healed and the	F 274	recuperation time longer than two weeks. The change in resident condition or status policy was reviewed with the MDS coordinator on 3/23/17. Using an audit tool, the MDS coordinator or designee will monitor changes in ADLs, changes in behavior, resident decision making, and incontinence to monitor resident status on a quarterly basis and acute conditions as they occur to avoid missing changes in the future. Results will be taken to QA&A monthly for three months and quarterly thereafter for one year for further review and analysis.	

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F 274	Continued From page 5 resident's care needs changed again. 2. Review of the 6/1/16 annual MDS assessment showed resident #22 required extensive assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. The following concerns were identified: a. Review of the 8/24/16 quarterly MDS assessment showed the resident had declined and was totally dependent on staff for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Review of the 11/18/16 quarterly MDS assessment showed the resident continued to be totally dependent in the same areas as assessed in the 8/24/16 quarterly MDS assessment. b. Observation on 3/1/17 at 1:30 PM revealed CNAs #1 and #2 provided total care for the resident when they transferred the resident from the wheelchair to the toilet, provided personal hygiene care, transferred him/her to the recliner chair and gave him/her a drink of water. c. Interview on 3/2/17 at 10 AM with the MDS coordinator revealed a significant change MDS should have been completed instead of a quarterly MDS on 8/24/16. 3. Interview with the DON and MDS coordinator on 3/1/17 at 4:40 PM revealed the facility had changes in staff at the MDS coordinator position and that was why the need for significant change assessments had not been identified. 4. Review of the policy titled "Change in a Resident's Condition or Status" last revised November 2015 showed "...2. A "significant change" of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by the staff or by	F 274		

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F 274	Continued From page 6 implementing standard disease related clinical interventions (is not "self-limiting"); b. Impacts more than one area of the resident's health status; c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument and 42 CFR 483.20(b)(ii)..." 5. Review of the "CMS RAI version 3.0 manual, October 2014," showed "...04. Significant change in status assessment (SCSA) (A0310A=04)... other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns)..." Continued review showed "...Decline in two or more of the following..,any decline in an ADL (activities of daily living) physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment." Further, the RAI stated a significant change assessment is appropriate when " ..,There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 274		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 7 483.24 Quality of life 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 medical record review and staff interview, the facility failed to ensure accurate administration of medications for 1 of 13 sample residents (#34) who received daily medications. The findings were: 1. Review of physician's orders for resident #34 showed an order dated 2/15/17 for Medrol 4 mg Dosepak (medication used to treat inflammatory conditions). Review of the instructions on the medication package showed the 4 mg pills were to be given in tapered doses of one less pill each	F 309	F309-DON notified physician on 3/1/17 of resident #34 not receiving the medication as ordered. The physician re-evaluated resident #34 on 3/8/17 with no new orders. Nurses will be re-educated on the process of noting and administering medications including clarifying any medication orders if original order does not specify all of the "Rights" of medication administration. Nursing staff was re-educated on policy that 2nd nurse is to verify medication orders with a second nurse for clarity and to avoid transcription errors. All nurses administering medications at the facility will have this education completed by 4/16/17. DON discussed the medication order and subsequent error involved with the physician and the pharmacist. The pharmacist and physician will make changes to ensure orders are written more specifically on the order itself as well as the medication labeling by April 16, 2017. DON and/or designee will audit all current medication orders for clarity using an audit tool by April 16, 2017. The DON or designee will review medication	4/16/17

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F 309	Continued From page 8 day. The following concerns were identified: a. Review of the February 2017 medication administration record (MAR) showed the order was transcribed as Medrol 4 mg Dosepak for sciatica to be given daily at 7 AM. Further review of the MAR showed on some days the resident received only one pill instead of the tapered dose number of pills. b. Interview with the DON on 3/1/17 at 10:45 AM revealed it was a transcription error because the medication was entered incorrectly on the MAR. She stated the order should have been clarified with the physician, and the medication should have been given according to the directions on the package. c. Interview with the pharmacist on 3/2/17 at 11:05 AM revealed the medication was for the resident's sciatic pain and in order to be effective should be given in tapering doses according to the directions on the medication. She further stated the error caused a delay in the effect of the medication.	F 309	orders using an auditing tool every two weeks for 3 months and quarterly thereafter for one year to ensure orders are written clearly and include the 5 rights of medication administration. Results will be taken to QA&A monthly for three months and quarterly thereafter for one year for further review and analysis.	
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		

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F 323	Continued From page 9 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview, medical record review and policy and procedure review, the facility failed to ensure bed assist bars were assessed related to safety for 6 of 6 sample residents (#2, #4, #11, #17, #29, #30) with falls out of or near a bed. The findings were: 1. Review of the 1/30/17 quarterly MDS assessment showed resident #2 had diagnoses that included schizophrenia, and had 2 falls since the prior assessment. The following concerns were identified: a. Observation on 3/1/17 at 10 AM showed the resident had an assist bar attached to the outside of his/her bed and the other side of the bed was placed against the wall. The assist bar was designed to have a gap that measured 3 1/2 inches by 17 inches and was large enough to place a limb through. b. Review of the resident's medical record showed no evidence that a safety assessment was completed. 2. Review of the 12/8/16 quarterly MDS assessment showed resident #4 had a diagnosis	F 323	F323-Assist bars on the beds of residents #2, #4, #11, #17 and #29 will be evaluated by therapy by 3/24/17 for risk versus benefit of assist bars including the potential for entrapment related to the "gap" versus the benefit provided to the resident by using the assist bar. It was determined that residents #4, #11, #17 and #29 will benefit from the use of the assist bar to increase their independence related to mobility. Resident #2's assist bars were removed on 3/24/17. Resident #30 has passed away. A safety assessment will be completed on all residents with assist bars by the Director of Rehab (DOR) or designee to determine risk related to safety versus benefit of assist bar for resident mobility by 4/16/17. All new residents admitted to the facility will be evaluated for risk versus benefit of assist bars by the therapy department in relation to the assist bars. Residents will be re-evaluated quarterly by DOR or designee for risk versus benefit of assist bars. Results will be taken to QA&A monthly for three months and quarterly thereafter for	4/16/17

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F 323	Continued From page 10 of non-Alzheimer's dementia and a BIMS score of 8 (moderately impaired). Further, the resident required the extensive assistance of one staff member for bed mobility and transfers and was not coded as having physical restraints while in bed. Medical record review showed the resident had a fall near his/her bed on 12/19/16. The following concerns were identified: a. Observation on 2/27/17 at 10:40 AM showed the resident had an assist bar to the outside of the bed and the other side of the bed was placed against the wall. The assist bar was designed to have a gap that measured 3 1/2 inches by 17 inches and was large enough to place a limb through. b. Review of the resident's medical record showed no evidence that a safety assessment was completed. 3. Review of the 1/19/17 quarterly MDS assessment showed resident #11 had diagnoses that included non-Alzheimer's dementia, peripheral vascular disease, and glaucoma. Further review showed the resident had severe cognitive impairment, a history of falls, and impaired vision. Medical record review showed the resident fell on 12/17/16, while trying to transfer from the bed to wheelchair without assistance. The following concerns were identified: a. Observation on 2/27/17 at 2:20 PM revealed an assist bar was attached to the outside of the resident's bed and the other side of the bed was placed against the wall. The assist bar was designed to have a gap that measured 3 1/2 inches by 17 inches and was large enough to place a limb through. b. Review of the resident's medical record showed no evidence that a safety assessment	F 323	one year for further review and analysis.	

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F 323	Continued From page 11 was completed. 4. Review of the 2/7/17 annual MDS assessment showed resident #17 had diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, and macular degeneration and had a BIMS score of 3 (severely impaired). Further, the resident required the extensive assistance of one staff member for bed mobility and transfers and was not coded as having physical restraints while in bed. Review of the medical record shows the resident had a fall near his/her bed on 08/11/16. The following concerns were identified: a. Observation on 2/27/17 at 10:40 AM showed the resident had an assist bar to the outside of the bed and the other side of the bed was placed against the wall. The assist bar was designed to have a gap that measured 3 1/2 inches by 17 inches and was large enough to place a limb through. b. Review of the resident's medical record showed no evidence that a safety assessment was completed. 5. Review of the 12/5/16 quarterly MDS assessment showed resident #29 had diagnoses that included non-Alzheimer's dementia and Parkinson's disease. Further review showed the resident had a history of falls, impaired memory, and impaired vision. Medical record review showed the resident fell from the bed to the floor on 11/10/16. The following concerns were identified: a. Periodic observations on 2/27/17, 2/28/17, and 3/1/17 revealed an assist bar was attached to the outside of the resident's bed and the other side of the bed was placed against the	F 323		

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PRINTED: 03/16/2017
FORM APPROVED
OMB NO. 0938-0391

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	535053	A. BUILDING _____ B. WING _____	03/02/2017

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F 323	Continued From page 12 wall. The assist bar was designed to have a gap that measured 3 1/2 inches by 17 inches and was large enough to place a limb through. b. Review of the resident's medical record showed no evidence that a safety assessment was completed. 6. Review of the significant change MDS dated 2/17/17 showed resident #30 had diagnoses that included depression, dementia, moderate to severe pain and a history of falls. Medical review showed the resident had a history of a femur fracture on 11/26/12. The following concerns were identified: a. Observation on 2/20/17 at 11 AM showed an assist bar was attached to the outside of the resident's bed and the other side of the bed was pushed up against the wall. The assist bar was designed to have a gap that measured 3 ½ inches by 17 inches and was large enough to place a limb through. b. Review of the medical record showed no evidence that a safety assessment for the assist bars had been completed. c. Interview with the resident's daughter on 2/27/17 at 2:10 PM revealed the resident recently had a fall out of bed after s/he attempted to get up without assistance. 7. Interview with the DON on 3/1/17 at 4:40 PM revealed the assist bars had not been assessed for safety related to resident limb entrapment and the assist bars were available on all beds of the facility, but not all residents used them. 8. Review of the policy titled "Bed Safety" last revised 12/2007 showed "...1. The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's	F 323		

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F 323	Continued From page 13 safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. 2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, siderails, headboard, footboard, and bed accessories), the facility shall promote the following approaches...e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.)..."	F 323		
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 (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:	F 329		

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F 329	Continued From page 14 Based on staff interview, medical record review, and policy and procedure review, the facility failed to ensure behavior monitoring was completed to identify medication necessity for 4 of 8 sample residents (#5, #11, #29, #36) who used psychotropic medications. The findings were: 1. Review of the 2/2/17 quarterly MDS assessment showed resident #5 had diagnoses which included Alzheimer's dementia and depression. Further, the resident had no symptoms of delirium present and a depression score of 0. Review of the behavior monitoring record for December 2016, January 2017, and February 2017 showed the medications used to treat behaviors were sertraline (antidepressant), Namenda (cognition enhancing), and Zyprexa (antipsychotic). Further review showed target behaviors included "anger, yelling at staff, residents," "Non-participation in activities," "withdrawn, flat affect" and "side effects: restlessness, anxiety, increased confusion, drowsiness." The following concerns were identified: a. Review of the behavior monitoring record for December 2016, January 2017, and February 2017 showed all of the identified target behaviors were tracked on a single form which did not indicate which medication was being used to treat specific behaviors. Further, the target behaviors were vague and non-specific. 2. Review of the 12/22/16 quarterly MDS assessment showed resident #36 had diagnoses which included Alzheimer's disease and anxiety. Further, the resident had no symptoms of delirium present and a depression score of 0. Review of the behavior monitoring records for December 2016, January 2017, and February	F 329	F329-The psychotropic medication behavior monitoring system was revised on 3/23/17 to address each medication more specifically for the diagnosis and /or behaviors for which the medication was ordered. On March 23, 2017 residents #5, 11, 29 and 36 have an individualized medication specific monitoring system in place. Nursing staff will be educated on the changes in behavior monitoring by April 16, 2017. All residents taking psychotropic medications will be audited (using an auditing tool) by DON or designee by April 16, 2017, to ensure each resident has an individualized behavior monitoring system in place that addresses medication prescribed for identified target behaviors. Medications will be reviewed every two weeks during medication reconciliation by DON/ ADON or designee to ensure residents taking psychotropic medication have the behavior monitoring system in place. Newly admitted residents with psychotropic medication as well as newly ordered psychotropic medication will have medication specific monitoring system added by DON or designee. Social	4/16/17

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F 329	Continued From page 15 2017 showed the medications used to treat behaviors were buspirone (antianxiety), Namenda XR (extended release), and Morphine XR (analgesic). Further review showed the target behaviors included "anger, yelling at staff, residents," "confusion," "withdrawn, flat affect," and "anxiety." The following concerns were identified: a. Review of the behavior monitoring record for December 2016, January 2017, and February 2017 showed all of the identified target behaviors were tracked on a single form which did not indicate which medication was being used to treat the specific behaviors. Further, the target behaviors were vague and non-specific. 3. Review of the 1/19/17 quarterly MDS assessment showed resident #11 had diagnoses that included non-Alzheimer's dementia and depression. Further review showed the resident had no symptoms of delirium and a depression score of 5 (mild depression). Review of the behavior monitoring records for December 2016, January 2017, and February 2017 showed the medications used to treat behaviors were lorazepam (antianxiety) and Zoloft (antidepressant). Further review showed the target behaviors were "anger, yelling at staff and residents," "non-participation in activities," "withdrawn flat affect," and "depressed mood." The following concerns were identified: a. Review of the behavior monitoring record for December 2016, January 2017, and February 2017 showed all of the identified target behaviors were tracked on a single form which did not indicate which medication was being used to treat the specific behaviors. Further, the target behaviors were vague and non-specific.	F 329	Services will review monthly to ensure all psychotropic medication is monitored for the specific behaviors and /or symptoms for which the medication was prescribed. All results will be taken to QA&A monthly for three months and quarterly thereafter for one year for further review and analysis	

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F 329	Continued From page 16 4. Review of the 12/5/16 quarterly MDS assessment showed resident #29 had diagnoses that included dementia, Parkinson's disease, and depression. Further review revealed the resident had no delirium and a depression score of 12 (moderate depression). Review of the behavior monitoring records for December 2016, January 2017, and February 2017 showed the medications used to treat behaviors were Seroquel (antipsychotic), Wellbutrin XL (antidepressant), Namenda (cognition enhancing) and Aricept (cognition enhancing). Further review showed the target behaviors were "anger, yelling at staff and residents," "non-participation in activities," "withdrawn flat affect," and "hallucinations." The following concerns were identified: a. Review of the behavior monitoring record for December 2016, January 2017, and February 2017 showed all of the identified target behaviors were tracked in a single form which did not indicate which medication was being used to treat the specific behaviors. Further, the target behaviors were vague and non-specific. 5, Interview with the DON on 3/2/17 at 9:16 AM confirmed the behavior monitoring record did not identify target behaviors for individual medications, and further confirmed the behavior monitoring record in its current form would not provide useful data on medication effectiveness. 6. Review of the policy titled "Medication Utilization and Prescribing-Clinical Protocol" last revised September 2012 showed "Assessment and Recognition 1. When a medication is prescribed in response to an identified problem,	F 329		

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F 329	Continued From page 17 condition, or risk, the physician and staff will identify the indications...Cause Identification...2. The physician and staff will evaluate the effectiveness and effects of the medications in a resident's regimen...Treatment/Management 11. The physician and staff will adjust existing medications based on their efficacy and the continued presence of relevant conditions and risks...Monitoring 1. The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to ensure the medication and dosage are still relevant and are not causing undesired complications,.."	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	F 371	F371- The ice machine including the upper water sealant molding and air filter where cleaned on 3/2/17. The ice machine cleaning log has been updated to include the date air filter and water sealant molding were cleaned. Ice machines have been put on a weekly cleaning schedule. Maintenance or designee will audit all ice machines by 4/16/17 to ensure cleanliness of machines including air filters and water sealant molding. Maintenance or designee will audit, using an audit tool, all ice machines monthly, to ensure cleanliness of machines, including the air filter and water sealant molding. All results will be taken to QA&A for further review and analysis for one year.	4/16/17

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F 371	Continued From page 18 foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the ice machine cleaning log, and manufacturer's instructions the facility failed to ensure sanitary conditions in 1 of 1 kitchens. The findings were: Observation on 2/27/17 at 10:31 AM and on 2/28/17 at 10 AM showed the interior of the kitchen ice machine had a build-up of dust along the upper water-sealant molding and the air filter was dusty. Review of the user manual for "Scotsman Ice Systems Prodigy Plus D Series stated "...The ice machine's water system should be cleaned and sanitized a minimum of twice a year..." and "...clean air filters when they become visibly dirty. They will need cleaning more often than the other items..." Review of the ice machine cleaning log revealed the ice machine was last cleaned and inspected on 11/16/16. Interview with the maintenance supervisor on 3/1/17 at 9:17 AM revealed he had last cleaned the ice machine and filter on 2/14/17, however, the cleaning log was not documented with that information. In addition, the maintenance supervisor confirmed the ice machine was in need of cleaning.	F 371		