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 _____	12/07/2017

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 12/4/17 through 12/7/17. The following common abbreviations are used throughout the document: CMS: Centers for Medicare and Medicaid Services CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(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 §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582		1/20/18

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

Electronically Signed | 12/28/2017

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F 582	Continued From page 1 resident 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: Based on medical record review and staff interview, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNC) information was provided to 3 of 3 sample residents (#37, #147, #148) who had a termination in/discharge	F 582	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The	

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F 582	Continued From page 2 from Medicare Part A services. The findings were: 1. Medical record review showed Medicare Part A services started on 10/27/17 and ended on 11/9/17 for resident #37. Further review showed the facility gave Advance Beneficiary Notice Non-coverage (ABN) information to the resident on 11/7/17, but did not include information about NOMNC. 2. Medical record review showed Medicare Part A services started on 8/24/17 and ended on 10/19/17 for resident #147. Further review showed the facility gave the resident's family member ABN information on 10/17/17, but did not did not include information about NOMNC. 3. Medical record review showed Medicare Part A services started on 10/13/17 and ended on 10/31/17 for resident #148. Further review showed the facility gave ABN information to the resident on 10/27/17, but did not include information about NOMNC. 4. Interview on 12/06/17 at 4:56 PM with the administrator verified the facility did not provided the NOMNC information as required by CMS. At that time the administrator stated he did not have an explanation for why the information had not been provided.	F 582	submission of this plan does not constitute agreement by the facility that the surveyors□ findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F 582 – Medicare Part A discharge forms The facility will ensure that NOMNC information is provided to all residents who have a termination in/ discharge from Medicare Part A services. The facility has ensured that the applicable NOMNC notice will be provided by 1/11/18 to residents #37 and #147. Resident #148 no longer resides in the facility. Administrator will audit previous three months of Medicare Part A discharges to ensure they receive the proper NOMNC notification paperwork. Business office manager was provided education on the appropriate forms ABN and NOMNC notice for Medicare Part A discharges on 12/11/17. Policy and Procedure was reviewed to ensure it reflected the requirements for Medicare A discharge. The Administrator or designee will conduct audits of all future Medicare A discharges for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The Administrator or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur monthly for	

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F 582	Continued From page 3	F 582	no less than three months or until ongoing compliance has been achieved.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment.	F 640		1/20/18

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F 640	Continued From page 4 (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure a discharge MDS was transmitted to CMS as required for 1 of 14 sample residents (#1). The findings were: Review of the MDS assessment record for resident #1 showed s/he was admitted to the facility on 6/7/17 and was discharged on 6/21/17. The 14-day MDS assessment with return not anticipated, was completed and submitted to CMS as required. The resident was readmitted to the facility on 7/26/17 and subsequently discharged to the community on 8/7/17. The MDS discharge assessment was completed, but had not been submitted to CMS at the time of the survey (122 days post discharge). Interview with the MDS coordinator on 12/7/17 at 10:10 AM revealed she was not aware of the need to submit the MDS assessment because the resident was private pay and CMS had instructed her not to submit a reimbursement MDS.	F 640	F 640 Transmitting resident assessment The facility will ensure that each resident discharge from the facility will have an assessment completed and transmitted to CMS upon discharge. The facility completed and transmitted the MDS discharge assessment for resident # 1 which was accepted by CMS on 12/12/17. The MDS coordinator or designee will audit the resident discharges from the last 3 months to ensure no other residents were effected. The Policy and procedure entitled Resident Assessment Instrument was reviewed and amended on 12/26/17. On 12/26/17 the MDS coordinator was re-educated on section 2.6 of the RAI manual covering required assessments. The MDS coordinator or designee will conduct audits of all future resident discharges for no less than 3 months to ensure compliance. Any problems	

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F 640	Continued From page 5	F 640	identified will result in immediate education and corrective action. The MDS coordinator or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur monthly for no less than three months or until ongoing compliance has been achieved.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 656		1/20/18

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F 656	Continued From page 6 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 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 observation, medical record review, and staff and family interview, the facility failed to ensure care plans were developed to include measurable objectives and individualized approaches for 4 of 13 sample residents (#23, #33, #39, #43). The findings were: 1. Review of the quarterly MDS assessment with an assessment reference date of 10/6/17 showed resident #23 used oxygen during the 7-day look period. Review of the physician orders showed the resident had a 3/28/17 order for oxygen 1-2 liters at bedtime to keep saturations above 90%. Review of the care plan, last reviewed 10/6/17, showed the care plan failed to address oxygen use. Interview with the MDS coordinator on 12/6/17 at 4:02 PM confirmed the care plan was available for staff use. She verified that oxygen use was not addressed on the care plan and it was something that should be addressed on the care plan. 2. Review of the 11/6/17 quarterly MDS assessment showed resident #39 required	F 656	F 656 Comprehensive care plans The facility will develop and implement comprehensive person-centered care plans for each resident residing in the facility. On 12/21/17 the care plans for the following residents were amended; Resident #23□s care plan was updated to reflect use of oxygen, Resident #39□s care plan was updated to reflect his/her bathing preferences, Resident #33□s care plan was updated to reflect the use of a mobility bar and Resident #43□s care plan was updated to address pain. The policy and procedure entitled Care Plans- Comprehensive was reviewed to ensure it addressed implementation of a comprehensive person centered care plan for each resident. All care plans will be audited to ensure all pertinent information including oxygen usage, bathing preferences, mobility and pain are addressed as applicable in their individual care plan.	

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F 656	Continued From page 7 extensive assistance for bathing and hygiene. Interview with the resident's family on 12/4/17 at 4:25 PM revealed concerns with bathing not being completed twice per week. The family felt like the facility staff gave the resident the option to refuse. Review of the 11/6/17 care plan failed to show any details related to bathing. Interview on 12/7/17 at 10:10 AM with the MDS coordinator revealed when the CNAs gave this resident a bath they were to follow instructions on the bath record, and let family know. However, she verified this information was not in the care plan, and should be added to the care plan. 3. Observation on 12/04/17 at 3:28 PM showed resident #33 was in bed sleeping. It was noted the resident had a mobility bar attached to the bed. Interview with RN #1 on 12/06/17 at 9:51 AM verified the resident used the mobility bar when getting in and out of bed. Review of the 10/23/17 assessment for the device showed it was safe and used to aid in bed mobility. The care plan of the same date showed the use of the mobility bar was not addressed. Interview on 12/7/17 at 10:10 AM with the MDS coordinator revealed information about the mobility bar should have been included in the care plan. 4. Review of a physician's progress note for resident #43 dated 9/13/17 revealed the resident had diagnoses which included knee osteoarthritis and rheumatoid arthritis. Review of the care plan under the section on "Nursing Concerns" revealed the resident had "knee pain as [s/he] has bone on bone in right knee joint" and "has arthritis in joints especially knees and has pain with activity." Review of the November and December 2017 MAR (medication administration record) showed the resident received meloxicam	F 656	The Quality Coordinator or designee will conduct a monthly random audit of comprehensive care plans based on scheduled MDS assessments to ensure care plans reflect the current medical, nursing, mental and psychosocial needs are addressed including use of oxygen, pain interventions, mobility needs and bathing preferences. Audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The Quality Coordinator or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur monthly for no less than three months or until ongoing compliance has been achieved.	

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F 656	Continued From page 8 (an anti-inflammatory and pain medication) 15 mg daily for chronic pain and had orders for PRN (as needed) tramadol (a pain medication) and acetaminophen. Review of the November and December 2017 TAR (treatment assessment record) showed a pain assessment was completed twice a day at 2 PM and 10 PM. Review of a comprehensive pain assessment dated 11/10/17 showed the resident scored an 18 which indicated mild risk. Review of the care plan dated 11/10/17 revealed pain had not been addressed. Interview with the MDS coordinator on 12/6/17 at 3:09 PM confirmed pain had not been included in the care plan.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff and resident interviews, the facility failed to complete a physical therapy evaluation for 1 of 6 sample residents (#41) reviewed for effective fall prevention measures. The findings were: Review of the 11/9/17 quarterly MDS assessment for resident #41 showed s/he had cognitive impairment, wandered 1 to 2 days each week, used a walker, and required supervision with walking and transfers. Review of the care plan,	F 689	F 689 Free of Accidents / hazards The facility will ensure that the residents receives adequate supervision and assistance devices to prevent accidents. Resident # 41 received a physical therapy screen completed on 12/14/17 and received doctors orders for therapy to work with resident #41 to improve strength. Physical therapy manager and nursing management received education	1/20/18

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F 689	Continued From page 9 revised 11/9/17, revealed the resident was at risk for falls and had diagnoses which included Alzheimer's disease and osteoporosis. Further review revealed the following interventions were implemented to address falls: wear non-slip shoes; observe for pain, possessions, position, and toileting needs; observe for appropriate use of walker; and remind to get up slowly when rising to reduce dizziness and lightheadedness. The following concerns were identified: a. Review of "Incident Investigations" reports for the past 6 months showed the resident was found in his/her room on the floor on 11/14/17 and again on 11/19/17. Further review revealed no serious injuries resulted from the incidents. Review of the post-fall evaluation completed after the resident fell on 11/19/17 showed recommendations for a perimeter mattress and a physical therapy evaluation of balance and strength. Review of the medical record on 12/6/17 revealed no evidence of a physical therapy evaluation. b. On 12/04/17 at 3:04 PM the resident was observed sitting in a chair at the table in the TV/lobby area. Continuous observation revealed the resident grasped the walker and attempted to rise to a standing position. S/he was unable to complete the movement and returned to a sitting position in the chair. Approximately 5 minutes later, s/he made slow and unsteady movements; and a second attempt to stand was successful. At that time s/he stated it was difficult to move from a sitting to standing position because his/her legs were "stiff." 2. Interview on 12/6/17 at 11:14 AM with the DON revealed staff made the decision not to apply the perimeter mattress because the mattress could cause injury to the resident when s/he sat on the	F 689	regarding timeliness of completion of screen requests and follow through on 12/27/17. The Quality Assurance Coordinator or designee will audit all other requested therapy evaluation / screenings from the last three months to ensure completion. The policy and procedure entitled "Safety and Supervision of Residents" was reviewed on 12/27/17 to ensure it addressed individualized, resident centered approach to safety. Audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The Quality Coordinator or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur monthly for no less than three months or until ongoing compliance has been achieved.	

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F 689	Continued From page 10 bedside. At that time the DON verified the physical therapy evaluation had not been done and stated the facility's usual practice was to complete such evaluations in a more timely manner.	F 689		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of employee files, review of facility CNA job description, and staff interviews, the facility failed to develop a system for ensuring 10 of 30 CNAs were competent in all areas of resident care. The findings were: Interview on 12/06/17 at 4:15 PM with the DON revealed the facility standard required all CNAs receive yearly competencies after they completed the new employee orientation competencies. She further stated the required competencies were identified on the new employee Competency Check List. Review of the new employee Competency Check List showed areas for CNA proficiency included the following: handwashing, hand sanitizer use, performing personal hygiene and catheter care, donning and removing gown, gloves, mask, and goggles, tub cleaning techniques, oral and denture care, providing bed baths, dressing residents, applying anti-embolism hose, making occupied beds, assistance with	F 730	F 730 Nurse Aide In-service education The facility will ensure staff receives appropriate yearly competency evaluation and training. All current employee records will be reviewed to identify those needing competency training. Any employees identified as not being current will be evaluated for competency using the "new employee and annual competency checklist". The policy and procedure entitled "Performance Evaluation Rating" was reviewed and amended on 12/26/17 to reflect the new competency evaluation process. DON was re- educated on timely completion of skills competency evaluations on 12/26/17 DON or designee will conduct random audits of employee records monthly to	1/20/18

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F 730	Continued From page 11 dining and positioning, and effective infection prevention practices. The following concerns were identified during review of employee files and interview with the DON on 12/06/17 at 4:15 PM: 1. The DON was in the process of developing a system for ensuring all CNAs received competencies annually, but she had not completed and implemented it. Eight CNAs had not received competencies and skills testing since before April 2016. 2. Evidence of competency and skills was lacking for 2 contracted CNAs. The facility system for competency testing for the contracted CNAs was for the CNAs to complete a self-assessment skills form based on experience within the last 2 years. The contract agency did not provide information that verified competencies for the CNAs. 3. Review of the job description for the CNAs revealed requirements for periodic testing for competency in specific areas of nursing care.	F 730	ensure competency evaluations are up to date. Audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The DON or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medically-related social service needs were followed-up on in a timely manner for 1 of 2 sample residents (#33) with medically-related	F 745	F 745 Medically related Social Services The facility will provide medically related social services to attain or maintain highest practicable physical, mental and psychosocial wellbeing of each resident.	1/20/18

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 _____	12/07/2017

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F 745	Continued From page 12 social service needs. The findings were: Review of the care plan with a review date of 10/23/17 showed resident #33 had pain related to wearing dentures and the dentures would be used only at meal times. Review of a social services note dated 11/17/17 at 3:23 PM showed the resident had complaints about his/her dentures hurting. The plan was to only put the dentures in for eating, keep them at the nurses station, and get orders for a topical pain medication to use on his/her gums. Further review of the note showed plans for the social services manager to make a follow-up call to the dentist regarding the medication. Interview with the social service manager on 12/06/17 at 11:47 AM verified she had made a call to the dentist regarding the medication for the resident's gums, but had not received a response. She confirmed no medication orders had been received; and stated an additional follow-up call to the dentist was needed.	F 745	Social service director contacted the dentist for resident #33 on 12/6/17 and a order was received on 12/8/17 for anbesol. The policy and procedure entitled "Social Services" was reviewed on 12/26/17 to ensure medically related social services is addressed. The Social Service Director was re-educated on 12-28-17 regarding timely follow up on medically related social service needs. Social service director or designee will audit previous 3 months of resident records to ensure that all medically related social service requests have had appropriate follow up. Social service director or designee will conduct random audits of all of medically related social service requests monthly to ensure compliance timeliness. Audits will be conducted for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The social service director or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		1/20/18

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F 758	Continued From page 13 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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F 758	Continued From page 14 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 2 of 5 sample residents (#3, #31). The findings were: 1. Review of the November 2017 medication administration record (MAR) showed resident #3 was receiving Seroquel (an anti-psychotic medication) 50 milligrams (mg) daily with a start date of 4/27/17. Further review showed a "Psychotropic Drug Review Form" dated 12/28/16 which showed the resident admitted in May of 2016 on Seroquel 100 mg twice daily, the dose was reduced in November 2016 to the current dose. Review of the 12/5/17 physician progress notes showed the Seroquel was for hallucinations, a complication of the resident's dementia. Review of the 11/23/16 physician's assessment/plan under the diagnosis "Lewy Body Dementia" showed the Seroquel was planned to be further reduced as it "was causing more hallucinations and anxiety." Review of the 9/13/17 physician assessment/plan under the diagnosis of "Parkinson's" showed "could increase Seroquel but at expense of sedation--not scary hallucinations to [him/her]." The following concerns were identified: a. Review of the medical record failed to show further attempts to reduce the dose of the Seroquel, and there was no clinical explanation made by the physician as to why a dose reduction should not be attempted.	F 758	F 758 Free from unnecessary Psychotropic meds/PRN use The facility will ensure that residents are free of unnecessary psychotropic medications Resident #3 anti-psychotic medications were reviewed by the physician on 12/7/17. Physician does not feel the benefit of reducing the Seroquel at this time outweighs the risks. Resident # 31 psychotropic medication was decreased on December 9, 2017. DON or designee will conduct an audit of all residents on psychotropic medications to ensure all residents have had GDR attempts in the appropriate time frames or a risk vs benefit analysis has been conducted. Any problems identified will result in immediate corrective action. The policy entitled "Anti-psychotic drug use" was reviewed on 12/26/17 to ensure the policy is in compliance with current psychotropic medication requirements. The psychotropic medication review team will be re-educated by 1/11/18 regarding completion of GDR or risk vs benefit analysis regulatory time-frame requirements. A performance improvement tool will be utilized by the DON or designee to conduct monthly audits to determine if GDR or risk vs benefit analysis have been	

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F 758	Continued From page 15 b. Interview with the DON on 12/06/17 at 2:17 PM verified no evidence a gradual dose reduction (GDR) for this medication had been attempted since the November 2016 reduction. 2. Review of physician orders for resident #31 showed Prozac (anti-depressant) 10 mg daily was ordered on 3/29/17 for major depressive disorder. Further review of the medical record showed a GDR had not been attempted, nor was there documentation from the physician to indicate a GDR would be contraindicated. Interview on 12/6/17 at 2:17 PM with the DON confirmed a GDR had not been attempted, but was due to be addressed in December.	F 758	completed as required. Any problems identified will result in immediate education and/or corrective action. Audits will be conducted for no less than 3 months to ensure compliance. The DON or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions,	F 838		1/20/18

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F 838	Continued From page 16 physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.	F 838		

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F 838	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility assessment and employee files, the facility failed to conduct and document a facility-wide assessment of needs and resources needed to provide competent resident care. The facility census was 48. The findings were: Interview on 12/4/17 at 10:35 AM with the DON and administrator revealed they had been working on the facility assessment, but were unsure about how to complete it. Review of the facility assessment revealed it did not include the following: a thorough assessment of the needs of the resident population; identified resources needed for the provision of care and services; an evaluation of the training program, contracted services, equipment maintenance, and necessary security measures; and a competency-based approach to determine staff knowledge and skills. Interview with the DON 12/06/17 at 4:15 PM and review of employee files revealed 10 CNAs currently employed had not received competencies and skills testing in accordance with the facility standards and the CNA job description. During interview on 12/7/17 at 9:30 AM, the administrator acknowledge the facility assessment was incomplete and relevant information was missing.	F 838	F 838- facility assessment The facility will ensure the facility assessment includes a thorough assessment of the needs of the resident population, identification of resources needed for the provision of care and services and evaluation of the training program, contracted services, equipment maintenance, necessary security measures and a competency based approach to determine staff knowledge and skills. The Quality Assurance team will be educated by 1/11/18 on the components required for a complete facility assessment. The current facility assessment will be reviewed and revised to include all necessary components required by the regulation by 1/20/18. The facility assessment will be reviewed at least quarterly by the Quality Assurance team over the next year to ensure the assessment reflects current needs of the facility. Any problems that are identified will result in revision of the facility assessment plan. All results and findings will be brought to QA&A for review and analysis.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 881		1/20/18

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F 881	Continued From page 18 a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of policy and procedure and staff interview the facility failed to ensure the antibiotic stewardship policy contained all required information. The census was 48. The findings were: 1. Review of the policy and procedure entitled "Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes," last revised 12/1/16, showed the policy failed to contain all required information. The following requirements were not included in the policy: a. The policy failed to develop antibiotic use protocols to address unnecessary or inappropriate antibiotic use. b. The policy failed to develop a mode of communication and frequency of education for prescribing practitioners and nursing staff on antibiotic use and the facility's antibiotic use protocols. 2. Interview on 12/7/17 at 10:30 AM with the DON revealed the infection control preventionist was out of the facility and confirmed the policy did not contain the required information.	F 881	F 881 Antibiotic Stewardship The facility will ensure the anti-biotic stewardship policy contains all required information The Infection Control Practitioner was re-educated on 12-28-17 regarding the components required for regulatory compliance regarding antibiotic stewardship. The Antibiotic Stewardship policy and procedure will be reviewed and revised by 1/11/18 include all necessary components required for regularly compliance. All staff including the medical practitioners will be re-educated by 1/11/18 on the revised antibiotic stewardship policy and procedure. Audits of all potential infections and the appropriate use of antibiotics will be conducted by the ICP or designee monthly for no less than 3 months to ensure compliance. The ICP or designee will report the results of audits at the QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		1/20/18

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F 883	Continued From page 19 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 20 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to implement a system for ensuring pneumococcal immunizations were offered for 1 of 5 sample residents (#42). The findings were: Review of the medical record for resident #42 showed staff had not offered the pneumococcal immunization, nor did they assess the resident for medical contraindication. Interview with the DON on 12/7/17 at 3:40 PM confirmed there was no documentation available regarding the administration of the vaccine.	F 883	F 883 Influenza and pneumococcal immunizations The facility will ensure that each resident is offered pneumococcal immunization unless the immunization is medically contraindicated or the resident has already been immunized. Resident # 42 was offered and will receive the pneumococcal vaccine on 1/2/18. The Infection Control Practitioner or designee will audit all current residents by 1/11/18 to ensure all current residents have been offered or have received the pneumococcal vaccine. The admissions coordinator and ICP were re-educated on 12/28/17 on the immunization policy and procedure to ensure understanding and adherence. Auditing of all new admissions will be conducted by the Infection Control Practitioner or designee for no less than 3 months to ensure compliance. The Infection Control Practitioner or designee will report the results of audits at the	

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F 883	Continued From page 21	F 883	QA&A meeting. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	