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	53A051	A. BUILDING _____ B. WING _____	01/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/7/18 to 1/10/18. The following common abbreviations are used throughout the document: ADL: Activities of Daily Living CDC: Centers for Disease Control and Prevention CEO: Chief Executive Officer 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		2/4/18

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

Electronically Signed | 02/02/2018

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.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure dignity for 2 of 15 sample residents (#9, #11) during care. The findings were: 1. Observation on 1/7/18 at 4:34 PM showed CNA #1 entered the room of resident #9. The CNA did not knock on the door, announce herself, or request permission to enter the room. While the CNA was providing care, the entry door was left open and the resident's alarm sounded. Continued observation showed RN #1 and CNA	F 550	Resident #9 Staff was educated on residents rights and how to enter a residents room appropriately on 1/30/18. Resident #1 Staff was educated on proper way to serve residents during meal time on 1/30/18. All facility residents are at risk, to protect our residents and prevent this from	

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F 550	Continued From page 2 #2 responded to the alarm and upon entry to the room did not knock on the door, announce themselves, or request permission to enter the room. Interview with the administrator on 1/8/18 at 5:47 PM revealed the facility expectation was for staff to knock prior to entering all resident rooms. 2. Observation on 1/7/18 at 5:38 PM showed resident #11 was sitting at a dining table with resident #7. Resident #7 received a meal tray at that time. Further observation showed resident #11 received a meal tray at 5:49 PM, after the resident made a verbal request for his/her tray to staff members, which was 11 minutes after the resident's tablemate was served. Interview with the administrator on 1/9/18 at 5:52 PM revealed residents should not wait longer than 5 minutes after their tablemates are served, to receive a meal tray.	F 550	happening to any other resident, SLNC have/will: Staff meeting held for all long term care staff with education provided on the state rules and regulations for 483.10 with a 10 question quiz given afterwards. Staff meetings were held on 1/30/18 and 2/1/18. Expectations were layed out for the long term care staff on - knocking on all residents doors prior to entering their rooms along with announcing themselves, this includes when a tab or bed alarm is going off. - Doors must be shut when providing any kind of resident care - When passing trays for all meals, they need to go table to table ensuring that all residents are served within 5 minutes of their table mates. DON or designee will monitor staff knocking on residents doors prior to entering along with tray pass on a weekly basis x 1 month starting the next week following the staff meeting (week of 2/4/18) then biweekly x 1 month starting month of March, then monthly x 1 month starting the month of April then on a quarterly basis. Results will be tracked on our QA/QI log. Any concerns will be reported to the QA/QI committee in the monthly meeting.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		2/9/18

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F 623	Continued From page 3 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		

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F 623	Continued From page 4 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 5 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide a written notice of transfer to 1 of 1 sample resident (#25) who had a facility-initiated transfer. The findings were: Review of a progress note dated 10/12/17 and timed 9:49 PM showed resident #25 was unresponsive and had no reported urine output for the day. The resident was transferred to the emergency department at 8:10 PM. Review of the medical record showed no indication the resident returned from the acute care facility and there was no evidence the facility issued a written transfer notice to the resident or the resident's representative. Interview with the administrator on 1/10/17 at 9:37 AM revealed resident #25 did not return from the acute care facility and the facility did not provide a written notice for transfer to the resident or the resident's representative.	F 623	Resident #25 Transfer form filled out on resident for the transfer for 10/12/17 and signed on 2/9/18. Chart audit performed from Oct. 2017 thru January 2018 and an additional 3 residents found with no transfer form. This was corrected on 2/9/18. A new Notice Of Proposed Transfer/Discharge form has been created covering all of the required information The form as been placed at the nurses station in a folder labeled Transfer Form All long term care nurses were educated on where the form is located and what the state regulations are for using the form on	

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F 623	Continued From page 6	F 623	February 1, 2018. DON or designee will track all transfers monthly x 3 months starting in February ensure that transfer forms are being used, and filled out correctly. After the 3 months of tracking this will continue to be a quarterly tracking project. Any concerns will be reported to the QA/QI committee in the monthly meeting.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		2/16/18

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F 625	Continued From page 7 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide written notice of the bed hold policy for 1 of 1 sample resident (#25) who had a facility-initiated transfer. The findings were: Review of a progress note dated 10/12/17 and timed 9:49 PM showed resident #25 was unresponsive and had no reported urine output for the day. The resident was transferred to the emergency department at 8:10 PM. Review of the medical record showed no indication the resident returned from the acute care facility and there was no evidence the facility issued written information on the bed hold policy to the resident or the resident's representative. Interview with the administrator on 1/10/17 at 9:37 AM revealed the facility did not provide written information on the bed hold policy to the resident or the resident's representative.	F 625	Resident #25 A Bed Hold form was completed for when the resident was transferred up to the ER and dated 2/9/18. To ensure that South Lincoln Nursing Center follows the state regulations we have: Created a new bed hold form that matches our facility policy The bed hold form has been placed at the nurses station clearly marked in a folder A copy of our bed hold policy will be sent out to all our residents and their families by 2/16/18. A copy of the bed hold policy and form has been placed in our admission packets, so that new residents will be aware of the policy upon admissions. All nurses were educated on the new form, its location and the state regulations on February 1, 2018. Nursing Staff to ensure bed hold policy/form are given and signed upon transfer/discharge or as soon as possible. A monthly log has been created "Facility Initiated Transfer Log" that will be faxed to	

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F 625	Continued From page 8	F 625	the Ombudsman on a monthly basis. The DON or designee will audit all transfers to make sure a bed hold form was filled out on a monthly basis x 3 months starting in February then quarterly. Any concerns will be reported to the QA/QI committee on a monthly basis.	
F 656 SS=D	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	F 656		2/19/18

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F 656	Continued From page 9 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 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, resident and staff interview, and policy and procedure review, the facility failed to ensure care plans were developed for 2 of 15 sample residents (#14, #15) with identified care plan needs. The findings were: 1. Review of a quarterly MDS assessment with an ARD of 11/16/17 showed resident #14 had diagnoses which included cerebrovascular accident, hemiplegia/hemiparesis, and unspecified dementia without behavioral disturbance. Further, the resident required extensive assistance for bed mobility, transfers, and toilet use, and was at risk for developing pressure ulcers. The following concerns were identified: a. Review of a Braden scale assessment dated 11/20/17 showed the resident was identified as a moderate risk for developing pressure ulcers. b. Review of the resident's care plan received	F 656	Resident #14 Care plan was updated to reflect the risk for skin breakdown per the Braden scale assessment. Care plan updated to reflect frequent positioning. Resident #15 Care plan was updated to reflect that the resident is a smoker. Chart Audit done for all 23 residents which showed that 3 of the 23 residents care plans were not reflecting proper updating. This was corrected on 2/15/18. SLNC will assign an RN to review all residents care plans on a bi-weekly schedule reflecting recent changes in our residents daily cares. This will be started the week of 2/11/2018 and be on-going	

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F 656	Continued From page 10 from the administrator on 1/8/18 at 6 PM showed no evidence a care plan was developed for positioning or mobility. c. Interview with the administrator on 1/9/18 06:09 PM revealed the resident should have a mobility/positioning care plan, and care plans should be implemented or updated with any resident changes. 2. Review of the medical record for resident #15 showed that s/he was admitted to the facility on 9/2/16 and returned to the facility following an acute care stay on 12/8/17. Interview with the resident on 1/08/18 at 11:07 AM revealed that s/he was a smoker and kept cigarettes and lighter in his/her possession. Review of the care plan received on 1/8/18 at 6:00 PM showed that no care plan had been developed for smoking safety. Interview with the MDS Coordinator on 1/10/18 at 9:30 AM confirmed that smoking was not addressed on the resident's care plan and should have been. 3. Review of the policy titled "Comprehensive Careplans" last revised on 2/7/06 showed "...Procedure: A. The careplan will describe services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being...C. Changes in condition will be reflected on the plan of care, with appropriate goals and approaches for every change in condition that exceeds 15 days. D. Problems, needs and deficits of the resident are identified through each discipline's assessment and through MDS and are listed on the plan of care with goals and approaches...F. The approaches describe the actions or duties to be done to meet the goal. They describe who, how,	F 656	RN that was assigned to review and update residents care plans on a bi-weekly process was educated by DON on 2/6/18. The assigned RN will communicate with the MDS Coordinator to ensure that she is aware of the changes made to the residents plan of cares. The DON or designee will track that all care plans are being updated on a bi-weekly schedule for the next 6 months starting in February then will continue to track on a quarterly basis. Any concerns found during the audit will be reported to the QA/QI committee monthly.	

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F 656	Continued From page 11 when, and what steps are involved. The approach should clearly reflect the coordination of the various disciplines in working toward meeting a common goal. G. The plan of care is a working tool and available for all staff involved in care delivery. An up-to-date plan of care is kept in the medical record; CAN [sic] approaches with corresponding goals are outlined and placed with every CNA flow sheet. Flowsheets [sic] are flagged whenever a new or revised plan of care is implemented. H. The writing and revising of the plan of care is the responsibility of the MDS coordinator. Each discipline is responsible for making sure the goals and approaches of the plan of care are consistent with the goals and approaches specified in the initial and quarterly assessments.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		2/15/18

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F 657	Continued From page 12 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to update care plans for 2 of 2 sample residents (#3, #14) with identified changes in care or interventions. The findings were: 1. Review of a quarterly MDS assessment with an ARD of 11/16/17 showed resident #14 had diagnoses which included cerebrovascular accident, hemiplegia/hemiparesis, and unspecified dementia without behavioral disturbance. Further, the resident had two or more falls with no injury, two or more falls with minor injury, and no falls with major injury since the last assessment. The following concerns were identified: a. Review of the progress notes between 11/20/17 and 1/9/18 showed the resident had 9 documented falls. b. Review of the fall care plan, last reviewed on 11/20/17, showed the resident was at risk for falls related to unsteady gait and poor balance. Further review showed no evidence new interventions were implemented related to falls between 11/20/17 and 1/9/18. c. Interview with the administrator on 1/9/18 at 5:54 PM revealed the care plan interventions were not specific to the resident and some of the	F 657	Resident #14 Resident's care plan was updated to show everything that is being offered/done to help prevent falls(1:1 activities with restorative aide or activities, repositioning between wheelchair and recliner, taking residents for walks and or wheelchair rides, providing and offering a snack or drink, offering the resident a puzzle). All nurses were notified and trained that even if the resident is care planned for falls with the bed in the lowest position and floor mats are on the floor, they still need to document a fall if the resident is found on the floor mats. This was done on 1/12/18. For resident #14 other interventions will be added and reviewed after each fall. DON or designee will audit all falls along with fall care plan for 3 months, reporting any concerns to QA/QI committee. Resident #3 Care plan was updated to reflect that the resident is on Lexapro instead of Paxil. this was done on 1/12/18.	

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F 657	Continued From page 13 interventions the facility used were not on the care plan. 2. Review of the care plan last reviewed 11/27/17 for resident #3 showed the resident received Paxil (antidepressant). The following concerns were identified: a. Review of the active pharmacy profile report showed no current order for Paxil; however, the resident had an order for Lexapro (antidepressant) which was started on 11/11/17. b. Interview with the MDS coordinator on 1/10/18 at 9:30 AM confirmed the resident was not on Paxil and this should have been changed on the care plan. 3. Review of the policy titled "Comprehensive Careplans" last revised on 2/7/06 showed "...Procedure: A. The careplan will describe services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being...C. Changes in condition will be reflected on the plan of care, with appropriate goals and approaches for every change in condition that exceeds 15 days. D. Problems, needs and deficits of the resident are identified through each discipline's assessment and through MDS and are listed on the plan of care with goals and approaches...F. The approaches describe the actions or duties to be done to meet the goal. They describe who, how, when, and what steps are involved. The approach should clearly reflect the coordination of the various disciplines in working toward meeting a common goal. G. The plan of care is a working tool and available for all staff involved in care delivery. An up-to-date plan of care is kept in the medical record; CAN [sic] approaches with corresponding goals are outlined and placed with	F 657	All 23 residents care plans were reviewed to ensure that they reflected the high fall risks, smokers, antidepressants, ect. 2 of the care plans did not reflect the residents current status, these were changed on 2/15/18. To ensure continued compliance with this state regulation, South Lincoln Nursing Center will: Have an RN review all residents care plans on a bi-weekly schedule to reflect recent changes in the residents daily care. This will start the week of 2/4/18 and be on going. Care plan updating will be audited monthly starting in February and be on going x 6 months then quarterly Any concerns found during the audit will be reported to the QA/QI committee monthly.	

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F 657	Continued From page 14 every CNA flow sheet. Flowsheets [sic] are flagged whenever a new or revised plan of care is implemented. H. The writing and revising of the plan of care is the responsibility of the MDS coordinator. Each discipline is responsible for making sure the goals and approaches of the plan of care are consistent with the goals and approaches specified in the initial and quarterly assessments.	F 657		
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 resident and staff interview, medical record review, and policy and procedure review the facility failed to ensure falls were investigated for 2 of 5 sample residents (#14, #15) reviewed with falls. Further, the facility failed to assess residents related to safe smoking for 2 of 2 sample residents (#15, #17) who smoked. The findings were: 1. Review of a quarterly MDS assessment with an ARD of 11/16/17 showed resident #14 had diagnoses which included cerebrovascular accident, hemiplegia/hemiparesis, and unspecified dementia without behavioral disturbance. Further, the resident had two or more falls with no injury, two or more falls with	F 689	Resident #14 Fall incident reports were completed for all 6 falls that were missing on incident log on 2/1/18. Implemented new interventions on residents care plan in an effort to minimize injuries from falls. Resident #15 Fall incident report completed for 11/19/17 on 2/1/18 Resident 15 will be assess quarterly for smoking safety starting in February 2018.	3/10/18

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F 689	Continued From page 15 minor injury, and no falls with major injury since the last assessment. The following concerns were identified: a. Review of the progress notes between 11/20/17 and 1/9/18 showed the resident had 9 documented falls. b. Review of the fall care plan last reviewed on 11/20/17 showed the resident was at risk for falls related to unsteady gait and poor balance. Further review showed no evidence new interventions were implemented related to falls between 11/20/17 and 1/9/18. c. Review of progress notes between 11/20/17 and 1/9/18 showed 6 falls where the resident was found on the floor next to his/her bed. The falls were not listed on the facility's incident log and occurred on 12/3/17, 12/19/17, 12/28/17, 12/29/17, 1/5/18, and 1/17/18. Further, there was no evidence of assessment for the falls, including a neurological assessment. d. Interview with the administrator on 1/9/18 2:43 PM revealed the facility did not complete an incident form or investigation when the resident was found on the floor next to the bed if the resident was on the fall mat, and the facility felt they had done all they could to prevent further falls for the resident. 2. Review of a progress note dated 11/19/17 and timed 3:56 AM showed resident #15 was found on the floor between the bed and wardrobe. The resident complained of pain in his/her right hip and right knee and was unable to bear weight on the affected leg. The on-call physician was notified and ordered the resident to go for xrays. Further review of the medical record showed that no incident report was filled out for the fall which resulted in a fracture to the right hip. Interview with the administrator on 1/10/18 at 9:52 AM	F 689	Resident #17 Resident will be assess quarterly for smoking safety starting in February 2018. All nursing staff was educated that when a resident is on the floor mats, it needs to be considered as a fall and documented as such. This was done on 2/1/2018. Chart audit will be done on the residents who have floor mats in place to see if any fall incident reports should have been made from Oct. 2017 thru Jan. 2018. This will be completed by 3/10/18. Incident reports will be completed for any identified falls and solutions to protect the residents. DON or designee will audit all smoking residents charts to ensure that an OT assessment is done quarterly. This will start January 2018. New assessments were completed on all smoking residents (2) in February 2018 and appropriate actions have been taken. Resident #15 and #17 are the only residents that smoke at the facility. DON or designee will audit monthly falls to ensure appropriate documentation is completed. This will start February 2018. DON or designee will audit quarterly smoking assessments by OT to ensure compliance. This will start February 2018. Any concerns will be reported to the QA/QI committee on a monthly basis.	

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F 689	Continued From page 16 confirmed that an incident report for the fall with fracture was not done and should have been done. 3. Review of the medical record for resident #15 showed that s/he was admitted to the facility on 9/2/16 and returned the facility following an acute care stay on 12/8/17. Further review of the medical record showed that s/he smoked cigarettes, however, no assessment for smoking safety was performed until 1/8/18. Interview with the resident on 1/08/18 at 11:07 AM confirmed s/he continued to smoke. 4. Review of the medical record for resident #17 showed the resident admitted to facility on 12/24/16. Further review of the medical record showed s/he smoked cigarettes, however, no assessment for smoking safety was performed until 12/1/17. Interview with the resident on 1/08/18 at 2:36 PM confirmed the resident smoked independently. 5. Interview with the administrator on 1/9/18 at 4:10 PM revealed there were no earlier smoking evaluations. Interview with the administrator on 1/09/18 at 7:16 PM confirmed that smoking evaluations should have been completed sooner than they were. 6. Review of the policy "Smoking in the Nursing Center" dated 11/10/17 showed that staff will "...perform an assessment on residents who smoke to assess their manual dexterity, hand-eye coordination, cognitive state and safety awareness at least yearly."	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		3/12/18

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F 727	Continued From page 17 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure there was a full time DON. The census was 23. The findings were: Interview with the administrator on 1/10/18 at 9:40 AM revealed since July 2017 she had been acting as the CEO, administrator, and DON. During that time, the administrator was also the DON for the hospital. A new CEO was hired and started on 1/8/18. The facility was "looking" at hiring an assistant for the administrator and the newly hired CEO was going to get his administrator's license; however, neither had occurred at that time.	F 727	All residents are at risk. DON is no longer acting as CEO effective February 1, 2018. Interim Administrator will obtain her Nursing Home Administrators License by the end of March 2018.And will be the full time Administrator for only the Nursing Home. An interim DON will be implimented by March 12, 2018. The facility will hire a full time DON for the Nursing Center end of March 2018. The DON position will be an RN with education on nursing home rules and regulations to help ensure compliance and resident safety. A full time DON will be hired for the	

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F 727	Continued From page 18	F 727	Hospital side of the facility who will take over all DON nursing roles by the end of March 2018. Board of Directors/CEO will ensure facility is staffed per regulations with any concerns being reported to the QA/QI committee monthly.	
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		2/2/18

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F 756	Continued From page 19 physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a drug regimen review was conducted for 5 of 5 sample residents (#3, #7, #12, #15, #20) reviewed for medication regimen. The findings were: 1. Review of the medical record for resident #3 showed the last drug regimen review was completed by a pharmacist on 9/6/17. 2. Review of the medical record for resident #7 showed the last drug regimen review was completed by a pharmacist on 9/6/17. 3. Review of the medical record for resident #12 showed the last drug regimen review was completed by a pharmacist on 9/6/17. 4. Review of the medical record for resident #15 showed the last drug regimen review was completed by a pharmacist on 9/6/17. 5. Review of the medical record for resident #20 showed no evidence a drug regimen review had been performed.	F 756	Drug regimen review was completed for resident #3, 7, 12, 15 and 20 on January 31, 2018 by the pharmacist and reviewed by the DON. Pharmacist reviewed all residents in the nursing center by February 2, 2018 and will continue to be reviewed on a monthly basis. The DON or designee will audit all 23 residents for MTM reviews each month throughout the year. The tracking will be on a monthly basis and continue throughout the year. All concerns and findings will be reported to the QA/QI committee monthly.	

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F 756	Continued From page 20 6. Interview with administrator on 1/9/18 at 2:06 PM revealed the full-time pharmacist left the facility in July and as-needed pharmacists were assisting the facility. The as-needed pharmacists did not routinely complete drug regimen reviews. 7. Review of the policy titled "Medications-Drug Regimen Review" dated 12/20/17 showed "...4. The pharmacist is responsible for reviewing each resident's drug regimen on a monthly basis. "Drug Regimen" includes all drugs which are currently ordered for the resident, including those drugs on order but have not been recently administered (PRN's)..."	F 756		
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, 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	F 758		3/12/18

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F 758	Continued From page 21 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 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, staff interview, and policy and procedure review, the facility failed to ensure appropriate psychotropic medication use for 2 of 5 sample residents (#7, #12) identified for a medication regimen review. The findings were: 1. Review of a monthly pharmacist review note dated 5/10/17 and timed 1:55 PM showed resident #7 received the medication escitalopram (antidepressant) and the medication was reviewed in the facility's psychotropic meeting.	F 758	Resident #7, #12, From July 2017 thru December 2017 South Lincoln did not have access to a full time pharmacist. All residents currently receiving psychotropic therapy are at risk. Request for GDR have been made to the residents primary care providers Since January 2018 SLNC has focused on the GDR for each resident, looking at their target behaviors with each	

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F 758	Continued From page 22 Further, the note indicated the resident's risk versus benefit statement would be reviewed that month. The following concerns were identified: a. Review of a physician's order dated 9/20/17 and timed 3 PM showed "Do not recommend decreasing residents [sic] Lexapro (escitalopram) 20 mg (milligrams) qd (every day) due to noted behaviors..." Review of the medical record showed no evidence of rationale or a risk benefit statement to indicate continued use. b. Interview with administrator on 1/9/18 at 2:06 PM revealed the full-time pharmacist left the facility in July, the facility utilized as-needed pharmacists to fulfill their needs, and gradual dose reductions or risk versus benefit statements were not completed for residents during that time. Continued interview confirmed a gradual dose reduction was not attempted for the resident and the physician wrote an order to continue the medication; however, there was no documentation to show the physician considered the risk versus benefit of the medication. 2. Review of the active pharmacy profile report for resident #12 showed the resident had orders for paroxetine (antidepressant) 40 mg one tab every day with a start date of 2/17/15, risperidone (antipsychotic) 0.5mg one tab twice a day with a start date of 10/4/17, and alprazolam (antianxiety) 0.25mg one to two tabs every six hours as needed with a start date of 7/21/17. The following concerns were identified: a. Review of the medical record showed there was a risk-benefit acknowledgement completed on 10/27/17 for risperidone and alprazolam; however, paroxetine was not addressed at that time. Further review of the medical record showed no evidence a gradual dose reduction (GDR) was attempted, nor	F 758	medication. 13 GDR's have been completed at this time with the final reviews being done in March 2018. Every resident will be reviewed at psychotropic drug review by the end of March 2018 with any GDR being addressed during those 3 months. SLNC's current Psychotropic Drug Initiation/Dosage Change policy is being reviewed and will be updated by March 31, 2018. A new tracking form for psychotropic drug review will be maintained with current up to date information for each resident, including the last risk benefit assessment. A risk benefit assessment will be done on all residents in SLNC by March 31 2018. All new residents will receive a risk benefit assessment within the first 7 days of admission and then yearly thereafter. Our current psychotropic drug review documentation forms have been changed to a more reliable form by having several different columns to document medication/dx for medication/start date/target behaviors/# prn doses in 30 days/# of each behaviors in 30 days/recommended actions/next review/last GDR for each medication To assist our providers with appropriate updates, they will receive a copy of the new form after each psychotropic drug	

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F 758	Continued From page 23 documentation from the physician to indicate a GDR would be contraindicated for the paroxetine. b. Interview with the administrator on 1/09/18 at 6:23 PM confirmed the resident was on paroxetine and a GDR had not been attempted. 3. Review of the policy titled "Psychoactive Drug Initiation/Dosage Change" dated 12/18/01 showed "...10) Drug reduction will be reviewed by psychotropic drug committee and provider as specified by federal regulations."	F 758	review for their records, and sign the form to be placed in the residents record. All Risk Benefit Assessments and Gradual dose reductions will be tracked as a QA/QI project for SLNC by the DON or designee on a monthly basis x 3 months then quarterly x 1 year. Any concerns will be brought up at the monthly QA/QI meeting.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		3/10/18

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	53A051	A. BUILDING _____ B. WING _____	01/10/2018

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F 761	Continued From page 24 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure medications available for resident consumption were not past the expiration date in 1 of 2 medication storage areas (medication cart). The findings were: Observation of the medication cart on 1/10/18 at 10:03 AM showed one card of the medication ranitidine 150 mg for resident #11 had an expiration date of 11/2017. Interview with LPN #1 at that time confirmed the medication was available for use and had an expiration date of 11/2017. Interview with the DON on 1/10/18 at 11:16 AM confirmed if an expired medication is found on the medication cart it is expected to be removed from the cart and disposed of. Review of the policy titled "Floor Stock" dated 8/6/07 showed "...As with all other medications, all floor stock (medications or chemicals) used to prepare medications are accurately labeled with contents, expiration dates and appropriate warnings..."	F 761	Resident #11 medication card that was expired as of 11/2017 was destroyed by pharmacy. Nursing staff educated on expired medications in med cart or medication storage room on 1/30/2018. Both medication cart and storage room were checked for further outdates on 2/15 and 3/10/18 to ensure no outdated medications are present with no further expired medications identified but all residents are at risk. Once a month either the Pharmacist or Pharmacy Tech will go through the medication cart and storage room to check for expired medications and destroy them. This will begin in February 2018 and be on going. The pharmacist or designee will audit that this is done monthly starting in February and be on-going. Any concerns will be reported to the QA/QI committee in the monthly meetings.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		2/15/18

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F 812	Continued From page 25 §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the 2013 food code, the facility failed to ensure food was stored and prepared in a sanitary environment in 1 of 1 food preparation area (main kitchen). The findings were: 1. Observation on 1/7/18 at 3:04 PM showed the "Hobart" oven was dirty with visible grease and debris on the exterior. Observation on 1/9/18 at 4:08 PM showed the oven remained dirty with visible grease and debris. 2. Observation of the walk-in cooler on 1/7/18 at 3:09 PM showed 1 cantelope quarter dated 12/29/17, and three blocks of sliced cheese wrapped in plastic wrap that were not labeled or dated. Further observation showed half of a tomato and half of an onion wrapped together in plastic wrap, half of a tomato wrapped individually in plastic wrap, and half of an orange wrapped in plastic wrap none of which were dated or labeled.	F 812	#1 Oven was cleaned on 1/14/18 #3 Fan cover cleaned on 1/14/18 In-service held with dietary staff on 2/12/18 to review cleaning and food storage procedures. Walk through of dietary facility done on 2/15/18 with no other problems identified. All residents are at risk. Oven placed on weekly cleaning schedule to be done by dietary department. Fan cover placed on a weekly cleaning schedule to be done by dietary department. Dietary manager to audit weekly to ensure food in fridge is packaged and labeled	

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F 812	Continued From page 26 Observation on 1/9/18 at 4:08 PM showed all the items remained in the walk-in cooler except the half tomato. 3. Observation of the walk-in freezer on 1/7/18 at 3:14 PM showed the fan cover was visibly soiled with dust and debris. 4. Interview with the dietary manager on 1/9/18 at 4:08 PM revealed items should be labeled, dated, and discarded after 3 days when stored in the walk-in cooler, the vents were to be cleaned by maintenance, and the oven should be cleaned weekly. 5. According to Food Code 2013, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. 6. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (D) and (E) of this section, refrigerated, READY-TO -EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR 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 812	correctly. Any concerns will be reported to the QA/QI committee at the monthly meetings.	
F 881	Antibiotic Stewardship Program	F 881		3/9/18

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F 881 SS=F	Continued From page 27 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 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 staff interview, and policy and procedure review, the facility failed to ensure an antibiotic stewardship program was implemented to identify appropriate antibiotic usage. The census was 23. The findings were: Review of the facility's infection control program showed no evidence the facility reviewed antibiotic usage or prescriptions. Interview with the administrator on 1/10/18 at 9:58 PM revealed the facility was limited on resources and antibiotics were only reviewed monthly. Further, she confirmed residents were sometimes started on antibiotics prior to cultures being returned and the facility did not have a pharmacist to review antibiotic usage. Review of the policy titled "Antibiotic Stewardship" received from the administrator on 1/10/18 at 12:15 PM showed "...Accountability:...Pharmacist will receive a copy of the orders stating what tests were done and if something was started prior to results. A copy of the lab results will be forwarded to the pharmacist so they can ensure that the resident is on the right antibiotic for the infection. Nursing Center-Charge nurse/DON will review the culture and sensitivity results ensuring that the resident is	F 881	Nursing staff was trained on 1/1/18 that we need to have a culture back before a resident is started on an antibiotic for treatment. Reviewed last 30 days of antibiotic orders for the month of February no residents started on antibiotics prior to cultures. All residents at risk. No antibiotic is being started until after the cultures are back and it is determined if the antibiotic will work for that infection. This was started on 2/1/18. All infections are tracked on a monthly basis, with daily follow up on the culture results. This started on 2/1/18 and will be on-going. All culture results will be sent to the Pharmacist, DON and residents provider to ensure that if an antibiotic is needed the right antibiotic is started. This will begin immediately.	

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F 881	Continued From page 28 on the right medication and contact the provider if we are using the wrong antibiotic..."	F 881	New forms will be created to ensure that we are following the McGeer guidelines in the nursing home. This will be done by 3/1/18 and nursing staff will be educated on the new forms and guidelines by 3/6/18 Antibiotic misuse will be audited on a weekly basis by the pharmacist or designee and reported to the DON and tracked as a QA/QI project Any concerns found during the audit will be reported to the QA/QI committee monthly.	