STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	03/29/2018

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/26/18 to 3/29/18. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living. BIMS: Brief Interview for Mental Status DON: Director of Nursing MAR: Medication Administration Record RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		5/5/18

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

Electronically Signed | 04/19/2018

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 583	Continued From page 1 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility failed to ensure residents received mail on Saturday. The facility census was 43. The findings were: 1. Interview with a group of 10 residents on 3/27/18 at 10:18 AM revealed they received mail on weekdays only and they did not receive mail on Saturday. 2. Interview with the activities coordinator on 3/27/18 at 11:50 PM revealed mail was delivered to the business office in the hospital. The facility activities staff picked up the mail and delivered it to the residents during the week. She stated the business office was closed on Saturday and they were not allowed to retrieve it. She further revealed she informed the administrator and DON about the lack of Saturday mail delivery, but nothing happened. 3. Interview with the DON on 3/27/18 at 2:37 PM confirmed mail was not delivered on Saturday.	F 583	A) The facility will ensure residents receive mail on Saturdays. B) All residents are affected by this practice. Clinic staff on duty on Saturdays will receive, sort and deliver AHCC mail to the nursing home. Activity staff will then deliver the mail to the residents. When the clinic is closed, mail will be directly delivered to the AHCC Activity staff to sort and deliver. C) Involved Clinic and Activity personnel will be advised of this plan. D) We will be implementing a performance improvement tool that will be utilized by the activities staff to track if mail was received at the facility on Saturdays. The tool will be filled out each week to note that mail was received at the facility and delivered to residents. This tool will be reviewed on a monthly basis at	

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F 583	Continued From page 2	F 583	team meetings and reported on a quarterly basis to the QAPI committee. The Activities Director will be responsible for compliance.	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure appropriate interventions were identified and implemented for 2 of 3 sample residents (#2, #22) with dementia. The findings were: 1. Review of the 12/21/17 annual MDS assessment showed resident #2 had diagnoses which included Alzheimer's dementia, anxiety disorder, and depression. Further review showed the resident had a brief interview for mental status (BIMS) score of 6 (indicating severe cognitive impairment), demonstrated disorganized thinking which fluctuated, and had other behavioral symptoms not directed toward others which occurred 1 to 3 days during the look-back period. The following concerns were identified: a. Review of the "cognitive loss dementia, impaired thought process" care plan, last modified on 1/5/18, showed no evidence resident-specific behavioral expressions or indications of distress had been identified. Further, there were no resident-specific	F 744	The facility will ensure appropriate interventions are identified and implemented for residents with dementia. A) Nurse Team Leader for resident #2 will update care plan to include resident-specific behavioral expressions or indications of distress. Nurse Team Leader for resident #22 will update care plan to include resident-specific behavioral expressions or indication of distress. Resident-specific non-pharmacological interventions will be identified and included in the care plan. B) The Nurse Team Leader for each floor and MSS will review care plans of all residents with dementia and update them as necessary to include specific target behaviors and individualized non-pharmacological interventions. C) DON will educate the two Nurse Team	5/11/18

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F 744	Continued From page 3 non-pharmalogical interventions identified. 2. Review of the 1/30/18 significant change assessment showed resident #22 had diagnoses which included dementia and anxiety disorder. Further review showed the resident had a BIMS score of 3 (indicating severe cognitive impairment), demonstrated inattention and disorganized thinking which fluctuated, wandered almost daily, and had other behavioral symptoms not directed toward others which occurred 4 to 6 days during the look-back period. The following concerns were identified: a. Review of the "cognitive loss dementia, impaired thought process" care plan, last modified on 2/4/18, showed no evidence resident-specific behavioral expressions or indications of distress had been identified. Further, there were no resident-specific non-pharmalogical interventions identified. 3. Interview with the unit manager on 3/29/18 11:34 AM confirmed the facility had not identified specific target behaviors or individualized non-pharmalogical interventions for these residents.	F 744	Leaders and MSS on the requirements to ensure resident care plans include specific target behaviors and individualized non-pharmacological interventions. D) Monthly the team leaders will utilize a PI tool to complete a monthly chart audit on every resident with a diagnosis of dementia. The PI tool will be used to verify that the resident's care plan has specific target behaviors and non-pharmacologic interventions identified. The tool will also verify based on a review of the behavior log that there is appropriate utilization of the non-pharmacological interventions. The results of the PI tool will be reported quarterly to the QAPI Committee. Nurse Team Leaders will be responsible for compliance.	
F 758 SS=E	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	F 758		5/11/18

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F 758	Continued From page 4 (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 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:	F 758		

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F 758	Continued From page 5 Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unneccessary medications for 3 of 5 sample residents (#2, #22, #36) reviewed for appropriate medication use. The findings were: 1. Review of the 12/21/17 annual MDS assessment showed resident #2 had diagnoses which included Alzheimer's dementia, anxiety disorder, and depression. Further review showed the resident had a brief interview for mental status (BIMS) score of 6 (indicating severe cognitive impairment), demonstrated disorganized thinking which fluctuated, and had other behavioral symptoms not directed toward others which occurred 1 to 3 days during the look-back period. Review of the physician's medication report printed on 3/28/18 showed the resident received vivactil (antidepressant), lamotrigine (mood stabilizer), lorazepam (antianxiety), escitalopram (antidepressant), and risperidone (antipsychotic). The following concerns were identified: a. Review of the lorazepam order showed 0.5 mg was ordered to be given by mouth twice per day as needed. There was no evidence the medication was ordered for less than 14 days. b. Review of the behavior monitoring documentation showed the facility was tracking behaviors related to the use of medications, including lorazepam, Namenda, lamotrigine, vivactil, escitalopram, and risperidone. Review of the March 2018 behavior monitoring showed the resident demonstrated target behaviors daily which included wanting to leave, worried about spouse, restlessness, agitated/combative, anger toward spouse, using foul language, dwelling on death of spouse, and refusing to get up. There	F 758	A) Nurse Team Leaders for residents #2, #22, and #36 will modify the resident's behavior monitoring document to show which target behaviors are being monitored for each medication. B) Nurse Team Leaders will audit behavior monitoring documents for all residents receiving psychoactive medications and modify them to include which target behaviors are being monitored for each medications. C) DON will review F158 regulatory requirements with the facility's two Nurse Team Leaders, stressing the need to identify which target behaviors are being monitored fore each medication. A2) Resident #2's PRN lorazepam order has been in place since admission on 10/13/14. Although the medication was not initially ordered for less than 14 days, on 12/1/17 the resident's primary physician noted the following rationale and duration: "Patient has anxiety that flares inconsistently and will require the prn dosing for lorazepam for at least the next twelve months." "Stopping the prn dose would be detrimental to the patient's condition." B2) In the future if a physician orders a PRN psychotropic drug, the facility pharmacist will notify the physician prior to the 14 days to remind him or her of the need to document his or her rationale and duration for the PRN order in the resident's medical record if the	

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F 758	Continued From page 6 was no method to determine which behaviors were being monitored for each medication. 2. Review of the 1/30/18 significant change assessment showed resident #22 had diagnoses which included dementia and anxiety disorder. Further review showed the resident had a BIMS score of 3 (indicating severe cognitive impairment), demonstrated inattention and disorganized thinking which fluctuated, wandered almost daily, and had other behavioral symptoms not directed toward others which occurred 4 to 6 days during the look-back period. Review of the physician's medication reported print on 3/28/18 showed the resident received buproprion SR (antidepressant), quetiapine (antipsychotic), and alprazolam (antianxiety). The following concerns were identified: a. Review of the behavior monitoring documentation showed the facility was tracking behaviors related to the use of medications, including buproprion, quetiapine, and alprazolam. Review of the March 2018 behavior monitoring showed the resident demonstrated target behaviors daily which included wandering, seeing things on the wall, wanting to go home, hitting staff, fear of being alone, and wanting family members. There was no method to determine which behaviors were being monitored for each medication. 3. Review of the 2/28/18 quarterly MDS assessment showed resident #36 had diagnoses that included dementia, anxiety, and depression. Review of current physician orders showed the resident had orders for Zyprexa (antipsychotic) and Celexa (antidepressant). The following concerns were identified:	F 758	practitioner believes it is appropriate for the PRN order to be extended. C2) Pharmacist will review F758, including the documentation requirements for PRN psychotropic drugs. The pharmacist will share this information with physicians at a Medical Staff meeting and individually as needed. D) A performance improvement tool will be implemented by the Team Leaders to ensure residents' drug regimens are free from unnecessary medications. Monthly PI review will include: A review of all residents on PRN Psychotropic Medications to verify compliance with the 14 day duration or appropriate documentation of the rational and duration for PRN orders beyond the initial 14 days. A behavior log review of every resident on a psychotropic medication to ensure that target behaviors are identified and monitored for each medication. The tool will be reported quarterly to the QAPI Committee. Nurse Team Leaders will be responsible for compliance in regards to monitoring target behaviors and pharmacist will be responsible for compliance regarding appropriate documentation for PRN psychotropic drugs.	

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F 758	Continued From page 7 a. Review of the behavior monitoring documentation showed the facility was tracking behaviors related to the use of medications, including Celexa and Zyprexa. Review of the March 2018 behavior monitoring showed the resident demonstrated target behaviors on 3 separate shifts, including paranioa, suspiciousness of staff, and crying. There was no method to determine which behaviors were being monitored for each medication. 4. Interview with unit manager #1 on 3/29/18 at 11:33 AM revealed the facility did not identify target behaviors in realtion to specific medications, and the effectiveness of the medication could not be determined.	F 758		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		5/11/18

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F 803	Continued From page 8 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of menus, the facility failed to ensure the menu was followed related to portion sizes during 1 of 1 meal service observation. The findings were: Observation on 3/28/18 at 4:50 PM of the evening meal service showed cook #1 served tuna noodle casserole using a #8 scoop (1/2 cup) and mixed vegetables using a 3 ounce scoop. Further observation showed all residents who ordered the tuna noodle casserole and mixed vegetables received this portion size. Review of the planned menu for the meal showed the serving size for the tuna noodle casserole was 1 cup and the serving size for the vegetables was a #8 scoop (1/2 cup). Interview with cook #1 on 3/28/18 at 5:25 PM revealed 1 scoop of casserole and vegetables was for residents who had orders for the regular portion size, and she did not fill the scoops all the way for the residents who had orders for a small portion. She was unable to state what the cup size equivalent was for a #8 scoop or a 3 ounce scoop. She stated the #8 scoop was "the one we usually use" for the main dish. Observation of the kitchen and office area showed no evidence of a chart or guide that showed conversions.	F 803	The facility will ensure the menu is followed related to portion sizes. A)B) All residents could be affected by this practice. A portion size/conversion measurement guide will be posted in the kitchen area for reference. DM or designee will randomly observe portions of at least 8 meal services per month to ensure serving sizes are appropriate. If not appropriate, immediate correction and in-servicing will be provided. C) The DM educated the serving staff on 3/29/18 as to the use of the posted menus with serving size, including the corresponding scoops for those portions. A review in-service will be giving to dietary staff on the appropriate use of the planned menus including portion sizes and conversions. D) A tool will be developed to ensure portion sizes are appropriate. This will be completed monthly and reported quarterly to the PI committee. This audit will continue for 3 months or until substantial	

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F 803	Continued From page 9 Interview on 3/29/18 at 9:05 AM with the certified dietary manager confirmed the portion sizes served were not correct. She further acknowledged that more training was needed for the dietary staff related to portion sizes. She stated residents with regular portion size orders were to receive the planned amount, residents with orders for small portion sizes were to receive half the planned amount, and residents with orders for large portions were to receive double the planned amount.	F 803	compliance is achieved. The DM is responsible for compliance.	