STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CODY REGIONAL HEALTH LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/11/18 to 6/14/18. Also reviewed in the course of the survey was complaint intake WY00002625. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 582 SS=D	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.	F 582		7/25/18

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

Electronically Signed | 07/06/2018

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 582	Continued From page 1 §483.10(g)(18) The facility must inform each 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 review of facility documentation and staff interview, the facility failed to issue the Skilled Nursing Facility Advanced Beneficiary	F 582	Preparation and/or execution of this plan of correction does not constitute the providers admission of or agreement with	

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F 582	Continued From page 2 Notice (SNFABN) to 2 of 3 sample residents (#22, #39) reviewed with a Medicare Part A stay. The findings were: 1. Review of a "SNF [skilled nursing facility] Beneficiary Protection Notification Review" form filled out by the facility showed resident #22 had a Medicare Part A episode starting on 3/2/18. Further review showed the last covered day of Part A services was 3/16/18. The form stated the facility initiated the discharge from Part A services before benefits were exhausted. The resident remained at the facility following the discontinuation of Part A services. 2. Review of a "SNF Beneficiary Protection Notification Review" form filled out by the facility showed resident #39 had a Medicare Part A episode starting on 3/20/18. Further review showed the last covered day of Part A services was 4/13/18. The form stated the facility initiated the discharge from Part A services before benefits were exhausted. The resident remained at the facility following the discontinuation of Part A services. 3. Interview with the administrative assistant and RN #3 on 6/13/18 at 5:32 PM revealed the residents were issued "Notice of Medicare Non-Coverage" forms prior to Medicare Part A services ending, but they were not issued SNFABN forms. They further stated they were unaware of the requirement to issue these forms upon discharge from Part A services when the resident was going to be remaining in the facility.	F 582	the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.Resident #22, # 39, # 3 continue to reside at this facility. Although an ABN notice cannot be given after the fact, notice has been given to these residents informing them of their rights to receive an ABN notice and that it will be provided to them going forward when they receive Medicare A services again. 2. All residents receiving Medicare A services will be reviewed to anticipate their discharge plan and need for an ABN. Since the time of the survey we have had 3 residents who have meet the conditions to receive an ABN notice and the notices have been provided as required. 3.All residents coming off of/or anticipating coming off of Medicare A services, will have the SNF beneficiary Protection Notification Review form completed to determine if they need to have an ABN Notice sent/delivered to them. Since the time of the survey we have had 3 residents who have meet the conditions to receive an ABN notice and the notices have been provided as required. The appropriate staff will be educated by the DON or designee on the	

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F 582	Continued From page 3	F 582	proper use of the ABN Notice. 4.All resident that are currently using Medicare A services or will be coming off of Medicare A services will be reviewed at the monthly QA meeting to ensure that the proper notices have been given	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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	F 623		7/20/18

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F 623	Continued From page 4 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 (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,	F 623		

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F 623	Continued From page 5 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. 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 ensure a transfer notice was issued to 3 of 3 sample residents with hospital transfers (#3, #5, #21). The findings were: 1. Review of the medical record showed resident #3 was transferred to the hospital on 6/5/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's	F 623	1. Resident #3, #5, #21 were transferred to the hospital and review of their medical records did not produce evidence of a transfer notice having been given. Notice has been sent to these residents informing them of their rights to receive the transfer/discharge notice and that they will receive it going forward should the circumstance warrant it.	

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F 623	Continued From page 6 representative. 2. Review of the medical record showed resident #5 was transferred to the hospital on 5/14/18 and readmitted to the facility on 5/24/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record showed resident #21 was transferred to the hospital on 3/7/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 4. During an interview on 6/14/18 at 9:54 AM the DON stated the facility was unable to locate evidence of written transfer notices for the sample residents.	F 623	2. All residents have the potential of a future transfer. The Notice of Transfer or Discharge form will be reviewed and updated by the Administrator or designee to ensure it is compliance with all current rules and regulations. The Staff will be educated by the DON or designee on the proper use of the updated Notice of Transfer or Discharge form to include: 1) Notification of the resident and the resident□s representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand, 2) That a copy of the notice is to be sent to a representative of the Office of the State Long-Term Care Ombudsman, 3) To record the reasons for the transfer or discharge in the resident□s medical record, 4) The timing of the notice is as follows: At least 30 days before the resident is transferred or discharged or as soon as practicable before transfer or discharge when A) the safety of individuals in the facility would be endangered, B) the health of individuals in the facility would be endangered, C) the resident□s health improves sufficiently to allow a more immediate transfer or discharge, D) an immediate transfer or discharge is required by the resident□s urgent medical needs, E) a resident has not resided in the facility for 30 days. 3. The DON or designee will ensure that the Nurses have Transfer/Discharge/Bed Hold packets at each nurses□ station with the appropriate forms to facilitate this	

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F 623	Continued From page 7	F 623	process. The forms will also be readily available to all staff on the facility□s share drive. The staff will be educated by the DON or designee on the proper use of the updated Transfer/Discharge/Bed Hold Notice form to include that the resident and the resident representative are provided written notice at the time of hospitalization or therapeutic leave. 4. The DON or designee will audit all transferred resident□s charts monthly to ensure that The Notice of Transfer or Discharge Form was completed appropriately as stated above and sent to all entities as required. The DON or designee will present the results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	
F 625 SS=E	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;	F 625		7/20/18

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F 625	Continued From page 8 (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 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 information on the bed-hold policy for 3 of 3 sample residents (#3, #5, #21) reviewed for transfers. The findings were: 1. Review of the medical record showed resident #3 was transferred to the hospital on 6/5/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 2. Review of the medical record showed resident #5 was transferred to the hospital on 5/14/18 and readmitted to the facility on 5/24/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 3. Review of the medical record showed resident	F 625	1. Resident #3, #5, #21 were transferred to the hospital and review of their medical records did not produce evidence of a bed hold notice having been given. Notice has been sent to these residents informing them of their rights to receive the bed hold notice and that they will receive it going forward should the circumstance warrant it. 2. All residents have the potential of a future bed hold need. The Bed Hold and Re-Admission Form will be reviewed and updated by the DON or designee to ensure that it includes the following: 1) The duration during which the resident is permitted to return and resume residence in the nursing facility. 2) The reserve bed payment policy. 3) The facility□s policy permitting a resident to	

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F 625	Continued From page 9 #21 was transferred to the hospital on 3/7/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 4. During an interview on 6/14/18 at 9:54 AM the DON stated the facility was unable to locate evidence of a written notice of the bed-hold policy for the sample residents.	F 625	return. The staff will be educated by the DON or designee on the proper use of the updated Bed Hold and Re-Admission form to include that the resident and the resident representative are provided written notice at the time of hospitalization or therapeutic leave. 3. The DON or designee will ensure that the Nurses have Transfer/Discharge/Bed Hold packets at each nurses□ station with the appropriate forms to facilitate this process. The forms will also be readily available to all staff on the facility□s share drive. The staff will be educated by the DON or designee on the proper use of the updated Bed Hold and Re-Admission form to include that the resident and the resident representative are provided written notice at the time of hospitalization or therapeutic leave. 4. The DON or designee will audit all transferred resident□s charts monthly to ensure that The Bed Hold and Re-Admission Form was completed appropriately as stated above. The DON or designee will present the results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI	
F 645	PASARR Screening for MD & ID	F 645		7/20/18

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F 645 SS=D	Continued From page 10 CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645		

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F 645	Continued From page 11 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure preadmission screening was completed prior to admission for 2 of 3 sample residents (#11, #69) reviewed. The findings were: 1. Review of the medical record showed resident #11 was admitted from the community to the facility on 3/7/18. A PASRR (pre-admission	F 645	1. Residents # 11, #69 PASARR Level 2 were completed after admission. 2. The Administrator or designee will audit all admissions for the months of April to present to determine if a PASARR Level 2 was completed if indicated prior to admission. Any PASARR Level 2 identified to have	

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F 645	Continued From page 12 screening and resident review) level 1 was completed on 3/7/18. A PASRR level 2 was triggered due to a psychiatric diagnosis of major depressive disorder and anxiety. Further review showed the PASRR level 2 screening was conducted on 3/19/18 and the determination completed on 3/27/18 (20 days after admission.) 2. Review of the medical record showed resident #69 was admitted from the community to the facility on 3/8/18. A PASRR level 1 was completed on 3/7/18. A PASRR level 2 was triggered due to a psychiatric diagnosis of major depressive disorder. Further review showed the PASRR level 2 screening was conducted on 3/19/18 and the determination completed on 3/27/18 (19 days after admission.) 3. Interview on 6/12/18 at 6:03 PM with the administrator and DON confirmed the residents were admitted to the facility before the PASRR level 2 was complete.	F 645	not been completed will be completed by the Administrator or designee. The Admission team will complete the PASARR Level 1 and if a Level 2 is indicated, the Admission team will notify the referring facility that the potential admission will be considered after completion of the PASARR Level 2 and evaluation of the cares required to determine if the admission is appropriate for this facility. 3. The Administrator or designee will educate the staff on the requirement for the PASARR Level 2, when indicated, to be completed prior to admission. The Admission team will complete the PASARR Level 1 and if a Level 2 is indicated, the Admission team will notify the referring facility that the potential admission will be considered after completion of the PASARR Level 2 and evaluation of the cares required to determine if the admission is appropriate for this facility. 4.The Administrator or designee will complete a monthly audit of all admissions to ensure that the PASARR Level 2, when indicated, was completed prior to admission. The Administrator or designee will present the results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	

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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 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	F 656		7/20/18

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F 656	Continued From page 14 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 interview, the facility failed to develop a comprehensive person-centered care plan for 2 of 16 sample residents (#34, #39) reviewed. The findings were: 1. Review of the 3/29/18 quarterly MDS assessment showed resident #34 had unclear speech, was rarely understood, had severe cognitive impairment, required the total assistance of staff for all ADLs, had a diagnosis of multiple sclerosis, was at risk for pressure ulcers, and was not on a turning/positioning program. Review of a pressure ulcer risk assessment dated 3/29/18 showed the resident scored 12 points which indicated the resident was at risk for developing pressure ulcers. The following concerns were identified: a. Observation beginning at 2:16 PM on 6/11/18 and ending at 5:26 PM (approximately 3 hours and 15 minutes) showed the resident was seated in a semi-upright position in a Geri-chair (a specialized reclining chair). The resident leaned to his/her right side and used a foam positioning wedge for support. During this time the resident was not provided assistance to reposition. Interview at 5:26 PM with CNA #1 revealed the resident usually laid down in the afternoon, but she was training a staff member and was not paying attention. b. Interview with RN #1 at 5:41 PM on 6/11/18 revealed sometimes the resident wanted to stay in the chair, but stated s/he had been sitting with his/her legs down for a long time. In addition, he	F 656	1. Resident # 34□s Skin/Wound/Pressure Reduction Care Plan will be updated by the DON or designee to include an appropriate repositioning schedule per Lippencott Nursing Procedures. Resident #39□s Care Plan will be updated by the DON or designee to include the appropriate use of Wheel Chair foot pedals individualized for the residents□ needs. 2. The DON or designee will audit all residents□ Care Plans to ensure that they include the following: 1) are person-centered, 2) Consistent with the resident□s rights, including the right to refuse treatment, 3) include measurable objectives and timeframes to meet medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment to attain or maintain the highest practicable well-being, 4) include goals for admission and desired outcomes, 5) preference and potential for future discharge. 3. The DON or designee will educate the staff on the appropriate development of a Care Plan to include the following: 1) the above stated items, 2) developed within 7 days after completion of the	

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F 656	Continued From page 15 stated the resident was able to tell them when s/he wanted to lay down. At this time the RN attempted to raise the leg lift on the Geri-chair, but was unable to do so. CNA #2 came over and stated she had tried to raise the resident's legs shortly after 2 PM but was unable to get the chair to work. After examining the chair the RN removed the straps of the transfer sling used for the mechanical lift from the operating mechanism of the Geri-chair and reclined the chair. c. Review of the "Skin/Wounds/Pressure Reduction" care plan last revised 4/5/18 showed the resident used a pressure-reduction mattress and a gel cushion in the wheeled recliner; however, repositioning of the resident was not addressed. d. Interview on 6/13/18 at 5:41 PM with the DON verified the care plan did not include repositioning of the resident. e. According to Lippencott, Nursing Procedures, Seventh Edition, 2015, page 633: under Pressure Ulcer Care showed "Implementation...Turn and reposition the patient every 1 to 2 hours or more frequently...For patients with limited mobility, use a pressure-redistribution device, such as air, gel..." 2. Review of the 4/2/18 admission MDS assessment showed resident #39 had diagnoses that included dementia, renal insufficiency, and other fractures. Further review showed the resident required extensive assistance for bed mobility and transfers. Review of the resident's care plan showed the resident had compression fractures of L2 and L5 vertebrae. The following concerns were identified: a. Observation on 6/11/18 at 5:01 PM showed the resident sitting in a wheelchair in the secure unit. There were two foot pedals attached to the	F 656	comprehensive assessment, 3) prepared by and interdisciplinary team (IDT) to include but not limited to the attending physician, a registered nurse (RN) with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services, the resident and their representative, to the extent practicable, and other appropriate staff of professionals in disciplines as determined by the resident□s needs or as requested by the resident, 4) reviewed and revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. The MDS Coordinator or designee will complete appropriate Care Plans upon admission, and with each MDS Assessment. 4. The DON or designee will audit the Care Plans during each Care Conference to ensure that they are as above stated. The DON or designee will present the results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	

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F 656	Continued From page 16 wheelchair, and the resident was resting his/her feet on the pedals. Observation on 6/12/18 at 4:36 PM showed the resident sitting in a wheelchair in the secure unit, with no foot pedals in place. 6/13/18 at 9:13 AM showed the resident was being wheeled to the main dining room to attend an activity. There were no foot pedals attached to the wheelchair. b. Interview with RN #4 on 6/14/18 at 8:11 AM revealed she was unsure when the resident required foot pedals placed on the wheelchair. She further asked if it was in the resident's care plan, then she asked CNAs #7 and #8 when the resident required foot pedals. The CNAs responded they were told to place the foot pedals when the resident was going to be wheeled out of the secure unit to other parts of the facility, in order to keep the resident's feet from dragging on the floor. c. Interview with occupational therapist #1 on 6/14/18 at 9:10 AM revealed the resident was discharged from therapy in April, and required foot pedals at the time of discharge because s/he was unable to follow directions to keep feet elevated to prevent being dragged along the floor while being pushed in the wheelchair by staff. She stated if the resident was able to follow directions to keep feet elevated, the foot pedals were not necessary. d. Review of the care plan showed no evidence the resident's use of foot pedals on the wheelchair, including indications for use, were included.	F 656		
F 657 SS=D	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	F 657		7/25/18

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F 657	Continued From page 17 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 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 observation, medical record review, and staff interview, the facility failed to ensure the individualized person-centered care plan was revised as needed to reflect the resident's current needs for 1 of 16 sample residents (#28) reviewed. The findings were: 1. Review of the 3/28/18 admission MDS assessment showed resident #28 was admitted to the facility on 3/21/18 and had diagnoses which included cancer and dementia. Further review showed the resident had a BIMS score of 11/15	F 657	1. The DON or designee has updated resident #28□s Urinary Incontinence Care Plan to reflect the resident□s current condition. 2. The DON or designee will audit all residents□ Care Plans to ensure that they include the following: 1) are person-centered, 2) Consistent with the resident□s rights, including the right to refuse treatment, 3) include measurable objectives and timeframes to meet	

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F 657	Continued From page 18 (moderate cognitive impairment); required the extensive assistance of one staff member for bed mobility, transfers, dressing, and toilet use; required supervision only for locomotion on the unit using a wheelchair; and was occasionally incontinent of bladder and bowel. The following concerns were identified: a. Observation on 6/12/18 at 1:45 PM showed the resident requested to be transferred from his/her wheelchair into a recliner in the common area on the east wing. Without addressing the resident's incontinence needs, CNA #3 transferred the resident with a full mechanical lift into the recliner. Observation of the resident while s/he was in the lift showed his/her incontinence product had leaked and his/her pants were wet. Interview with CNA #3 at 1:50 PM revealed she had changed the resident before lunch, but the resident was a "heavy wetter." b. Review of the urinary incontinence care plan last revised 4/4/18 revealed the resident had "some bladder leakage and urgency" and further was "dependent using the toilet and managing any incontinence." c. Interview with CNA #5 on 6/14/18 at 8 AM revealed the resident was continent of urine when s/he was admitted, but had declined and was currently incontinent. d. Interview with CNA #6 on 6/14/18 at 10:38 AM revealed the resident was incontinent even before she began using the full mechanical lift for transfers. Further, she would toilet or check and change the resident before and after meals, but there was nothing in the resident's care plan in regard to scheduled incontinence care. e. Review of the transfer care plan dated 5/17/18 showed a full mechanical lift for transfers was initiated.	F 657	medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment to attain or maintain the highest practicable well-being, 4) include goals for admission and desired outcomes, 5) preference and potential for future discharge. 3. The DON or designee will educate the responsible staff on the appropriate development of a Care Plan to include the following: 1) the above stated items, 2) developed within 7 days after completion of the comprehensive assessment, 3) prepared by and interdisciplinary team (IDT) to include but not limited to the attending physician, a registered nurse (RN) with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services, the resident and their representative, to the extent practicable, and other appropriate staff of professionals in disciplines as determined by the resident□s needs or as requested by the resident, 4) reviewed and revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. The MDS Coordinator or designee will complete appropriate Care Plans upon admission, and with each MDS Assessment. The Staff will be educated by the DON or designee to notify the IDT by email concerning any noted changes of a resident. If the identifying staff is not a	

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F 657	Continued From page 19 f. Interview with the DON on 6/13/18 at 5:24 PM revealed the facility's standard was to check for incontinence needs before meals and as needed. She further confirmed scheduled incontinence care was not addressed on the care plan.	F 657	nurse they will notify the appropriate nurse of the resident's change. The nurse will make the necessary changes to the resident's Care Plan. The IDT will follow up on the following work day to ensure that the Care Plan was updated and evaluate for any further changes that may need to be made. 4. The DON or designee will audit the Care Plans during each Care Conference to ensure that they are as above stated. The DON or designee will present the results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents unable to carry out activities of daily living received services to maintain personal hygiene for 1 of 4 (#28) sample residents reviewed for activities of daily living. The findings were: 1. Review of the 3/28/18 admission MDS assessment showed resident #28 was admitted	F 677	1.Resident #28□s Care Plan, Kardex and Nursing Worklist has been updated to ensure that the CNA□s are providing appropriate toileting care in a timely manner for this resident. 2. The DON or designee will audit all residents□ charts to identify residents unable to provide self-toileting cares.	7/20/18

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F 677	Continued From page 20 to the facility on 3/21/18 and had diagnoses which included cancer and dementia. Further review showed the resident had a BIMS score of 11/15 (moderate cognitive impairment); required the extensive assistance of one staff member for bed mobility, transfers, dressing, and toilet use; required supervision only for locomotion on the unit using a wheelchair; and was occasionally incontinent of bladder and bowel. The following concerns were identified: a. Observation on 6/12/18 at 1:45 PM showed the resident requested to be transferred from his/her wheelchair into a recliner in the common area on the east wing. Without addressing the resident's incontinence needs, CNA #3 transferred the resident with a full mechanical lift into the recliner. Observation of the resident while s/he was in the lift showed his/her incontinence product had leaked and his/her pants were wet. Interview with CNA #3 at 1:50 PM revealed she had changed the resident before lunch, but the resident was a "heavy wetter." b. Interview with the DON on 6/13/18 at 5:24 PM revealed the facility's standard was to check for incontinence needs before meals and as needed.	F 677	Identified residents Care Plan, Kardex and Nursing Worklist will be updated by the DON or designee to ensure that the CNAs are providing appropriate toileting care in a timely manner for each residents needs. 3. The DON or designee will educate CNA #3 on the appropriate toileting care to provide for residents unable to carry out activities of daily living (ADLs). The DON or designee will educate all staff on the appropriate toileting care to be provided for each resident unable to carry out ADLs per their individual Toileting Care Plans. The Admission nurse or designee will Ensure that the residents Kardex, Care Plan and Nursing Worklist reflect each residents ADL needs to ensure that the CNAs are providing appropriate toileting care in a timely manner for each residents needs. The facility is currently in the process of changing to a different electronic ADL charting system which will enable us to monitor ADL performance and identify those residents that need assistance and thus enable the care plans to be updated more quickly. 4. The DON or designee will audit the Worklist and CNA charting monthly to ensure that appropriate toileting care is occurring. The DON or designee will present the results of the audit at the QAPI meetings.	

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F 677	Continued From page 21	F 677	The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents received care to prevent pressure ulcers in 1 of 5 (#34) sample residents reviewed for positioning and pressure ulcers. The findings were: 1. Review of the 3/29/18 quarterly MDS assessment showed resident #34 had unclear speech, was rarely understood, had severe cognitive impairment, required the total assistance of staff for all ADLs, had a diagnosis of multiple sclerosis, was at risk for pressure ulcers, and was not on a turning/positioning program. Review of a pressure ulcer risk	F 686	1. Resident # 34□s Care Plan, Kardex and Worklist will be updated by the DON or designee to ensure that the resident□s position is changed and appropriate interventions are made per professional standards of practice. 2. The DON or designee will audit all charts to identify residents that are unable to change their positions or unable to request that their positions be changed and appropriate interventions made per professional standards. Identified residents Care Plan, Kardex	7/20/18

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F 686	Continued From page 22 assessment dated 3/29/18 showed the resident scored 12 points, which indicated the resident was at risk for developing pressure ulcers. The following concerns were identified: a. Observation beginning at 2:16 PM on 6/11/18 and ending at 5:26 PM (approximately 3 hours and 15 minutes) showed the resident was seated in a semi-upright position in a Geri-chair (a specialized reclining chair). The resident leaned to his/her right side and used a foam positioning wedge for support. During this time the resident was not provided assistance to reposition. Interview at 5:26 PM with CNA #1 revealed the resident usually lies down in the afternoon, but she was training a new employee and was not paying attention. b. Interview with RN #1 at 5:41 PM on 6/11/18 revealed sometimes the resident wanted to stay in the chair, but stated s/he had been sitting with his/her legs down for a long time. In addition, he stated the resident was able to tell them when s/he wanted to lay down. At this time the RN attempted to raise the leg lift on the Geri-chair, but was unable to do so. CNA #2 came over and stated she had tried to raise the resident's legs shortly after 2 PM but was unable to get the chair to work. After examining the chair the RN removed the straps of the transfer sling used for the mechanical lift from the operating mechanism of the Geri-chair and reclined the chair. c. Review of the "Skin/Wounds/Pressure Reduction" care plan last revised 4/5/18 showed the resident used a pressure-reduction mattress and a gel cushion in the wheeled recliner, however repositioning of the resident was not addressed. d. Interview on 6/13/18 at 5:41 PM with the DON verified the care plan did not include repositioning of the resident.	F 686	and Worklist will be updated by the DON or designee to ensure that the residents□ position is changed per professional standards of practice. 3. The DON or designee will educate RN #1 and CNA #1 on the appropriate repositioning and interventions for residents consistent with professional standards of practice The DON or designee will educate all staff on the appropriate repositioning needs and interventions to be provided according to the residents□ Skin/Wounds/Pressure Reduction Care Plan. The Admission nurse or designee will Ensure that the residents□ Kardex, Care Plan and Nursing Worklist reflect each resident□s ADL needs to ensure that the CNA□s are providing appropriate positioning care and interventions in a timely manner for each residents□ needs. The facility is currently in the process of changing to a different electronic ADL charting system which will enable us to monitor ADL performance and identify those residents that need assistance and thus enable the care plans to be updated more quickly. 4. The DON or designee will audit the Worklist and CNA charting monthly to ensure that appropriate repositioning is occurring. The DON or designee will present the results of the audit at the QAPI meetings.	

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F 686	Continued From page 23 e. According to Lippencott, Nursing Procedures, Seventh Edition, 2015, page 633: under Pressure Ulcer Care showed "Implementation...Turn and reposition the patient every 1 to 2 hours or more frequently...For patients with limited mobility, use a pressure-redistribution device, such as air, gel..."	F 686	The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview and staff interview, the facility failed to ensure treatment and services for range of motion limitations were provided for 1 of 3 sample residents (#30) reviewed for restorative and rehabilitation needs: The findings were: 1. Review of the 3/21/18 quarterly MDS	F 688	1. The DON or designee will request that Resident #30 be evaluated by therapy to establish an up to date Restorative Program. The Restorative Aide will follow the updated Restorative Program recommendations set forth by the Therapy evaluation.	7/20/18

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F 688	Continued From page 24 assessment showed resident #30 had a BIMS score of 15/15 (cognitively intact); diagnoses which included paraplegia; bilateral range of motion impairment to his/her lower extremities; and received restorative services for 1 day of the 7-day look-back period. Review of the physical therapy referral form dated 1/12/18 showed an upper and lower extremity active assist to passive range of motion restorative program was recommended 3 to 4 times per week to maintain extremity range of motion. The following concerns were identified: a. Interview with the resident on 6/11/18 at 2:58 PM revealed s/he had not received restorative services for "2 months" and s/he thought it was a staffing problem because one of the facility's restorative aides had resigned. b. Review of the medical record showed the resident received restorative services which included passive range of motion 2 times per week in March 2018; twice in April 2018 (4/3 and 4/27), and twice in May 2018 (5/3 and 5/8). There was no evidence restorative services were received in June 2018. c. Interview with the DON on 6/13/18 at 4:41 PM revealed the facility had two restorative aides but one had resigned and at that time had not been replaced. Interview with the administrative assistant revealed the restorative aide's last day of employment was 4/20/18. The remaining restorative aide worked Monday through Friday. Review of the facility's schedule showed during the week of May 28 through June 1, 2018 no restorative was scheduled due to a holiday, an injury, and the restorative CNA being reassigned to work on the floor.	F 688	2. The DON or designee will audit all residents' charts for orders for participation in the Restorative Program and for accuracy in the application of the orders in the Restorative schedule. The DON or designee will develop an appropriate Restorative Care Plan for the identified residents. 3. The DON or designee will educate the Restorative aide on appropriately maintaining the Restorative Program to ensure that each resident is receiving services as ordered. The DON or designee will monitor the Staff Schedule weekly to ensure that the Restorative Aide is completing the Restorative Program as ordered. 4. The DON or designee will audit the Restorative Program weekly to ensure that the Restorative Aide is completing the Restorative Program for each resident as ordered. The DON or designee will present the results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		7/25/18

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F 695	Continued From page 25 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure oxygen was delivered as ordered for 1 of 2 sample residents (#21) reviewed for respiratory care. The findings were: 1. Review of the 3/16/18 readmission MDS assessment showed resident #21 had severe cognitive impairment, required the extensive assistance of one staff member for all ADLs, and required oxygen. Review of a physician's progress note showed the resident was admitted to the hospital on 3/7/18 and discharged back to the facility on 3/9/18. The resident was "noted to have increasing oxygen requirements in the nursing home" and was diagnosed with acute congestive heart failure. Review of physician orders showed oxygen per nasal cannula was ordered at 2 LPM (liters per minute) with a start date of 3/9/18. Review of the care plan dated 3/26/18 showed "I use oxygen at 2 LPM at all times." The following concerns were identified. a. Observation on 6/11/18 at 11:03 AM showed the resident was seated in his/her wheelchair in the common area of the east wing. An oxygen tank was attached to the back of the wheelchair, however the resident was not wearing	F 695	1. Resident #21 remains with an order for continuous oxygen use at 2 LPM. The Care Plan reflects this order. The DON or designee will update Resident #21□s Kardex and Worklist to ensure that oxygen is used per the physician orders. 2. Daily random audits will be conducted on those residents using O2 to ensure residents have oxygen on will be completed on at least 5 residents using O2 for 3 weeks. Once continual compliance is achieved the audits will be tapered to 3 times per week for an additional 3 weeks, then 1 time per week for 3 weeks, then 2 times per month continually to ensure continued compliance. The DON or designee will audit all residents□ charts for orders for oxygen use. The DON or designee will update identified residents□ Care Plans, Kadex and Worklists to ensure that oxygen is being used as ordered.	

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F 695	Continued From page 26 a nasal cannula for oxygen. Observation at 11:37 AM showed the resident was located in the dining room, and was not wearing a nasal cannula for oxygen. b. Observation on 6/13/18 at 3 PM showed the resident was in bed with a nasal cannula in place. Interview with CNA #4 at this time revealed the resident only needed oxygen when s/he was in bed and not when sitting upright in a wheelchair. c. Interview on 6/13/18 at 4:40 PM with the DON confirmed the physician had not changed the order for oxygen and it should have been in use at all times.	F 695	3. Daily random audits will be conducted on those residents using O2 to ensure residents have oxygen on will be completed on at least 5 residents using O2 for 3 weeks. Once continual compliance is achieved the audits will be tapered to 3 times per week for an additional 3 weeks, then 1 time per week for 3 weeks, then 2 times per month continually to ensure continued compliance. The DON or designee will educate CNA #4 on the appropriate use of oxygen for this resident per the Care Plan. The DON or designee will educate all staff on the appropriate use of oxygen to be provided per the Residents□ Care Plan and Physician orders. The Admission nurse or designee will ensure that the Care Plan, Kardex, and Nurse Worklist include oxygen use as ordered. 4. Daily random audits will be conducted on those residents using O2 to ensure residents have oxygen on will be completed on at least 5 residents using O2 for 3 weeks. Once continual compliance is achieved the audits will be tapered to 3 times per week for an additional 3 weeks, then 1 time per week for 3 weeks, then 2 times per month continually to ensure continued compliance. The DON or designee will audit the Worklist monthly to ensure that	

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F 695	Continued From page 27	F 695	appropriate oxygen use is occurring. The DON or designee will present the results of the audit at the QAPI meetings. The audits will continue until continual compliance for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	
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 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	F 758		7/20/18

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F 758	Continued From page 28 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 and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 1 of 5 sample residents (#55) reviewed for medications. The findings were: Review of the 9/3/18 quarterly MDS assessment showed resident #55 had diagnoses including dementia. Further review showed the staff assessed the resident as being severely cognitively impaired, and the resident did not exhibit any behaviors during the look-back period. Review of current physician orders showed the resident was prescribed Ativan (antianxiety medication) 0.25 mg daily and Paxil (antidepressant) 20 mg daily. The following concerns were identified: a. Review of the order for Ativan showed the order date was 5/10/17. Further review showed	F 758	1. The Pharmacist or designee has requested that the Physician review Resident #55's Ativan and Paxil for a Gradual Dose Reduction (GDR) and document the risk/benefit if no GDR is recommended. 2. The Pharmacist or designee will audit all residents Medical records to identify all residents that are ordered Psychotropic medications. The Pharmacist or designee will request GDR's for any identified residents from their Physicians if applicable. 3. The Facility's Medical Director will educate the Physicians on the necessity	

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F 758	Continued From page 29 no evidence a gradual dose reduction (GDR) had been attempted, or the resident's physician provided justification for continued use. b. Review of the order for Paxil showed the order date was 2/25/16. Further review showed no evidence a GDR had been attempted, or the resident's physician provided justification for continued use in the past 12 months. c. Review of a medication regimen review dated 4/10/18 showed the pharmacist recommended discontinuing the resident's Ativan. Further review showed the physician responded "No thank you," with no justification for continued use. d. Interview with the DON on 6/14/18 at 10:26 AM confirmed there was no evidence of an attempted GDR or physician documented risk-benefit statement for the Ativan or Paxil for the past 12 months.	F 758	of the facility to ensure the following for use of all Anti-psychotic, Anti-depressant, Anti-anxiety, and Hypnotic medications: 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, 2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs, 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, 4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided 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, 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. The Medical Review Team will meet monthly to review residents with orders for Psychotropic medications. The Pharmacist or designee will request GDR□s from the Physicians when applicable. The Pharmacist or designee will notify the Medical Director of all	

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F 758	Continued From page 30	F 758	requests that have not been obtained from the physicians monthly. The Medical Director or designee will contact the Physicians to obtain the requested GDR□s. 4. The Pharmacist or designee will audit all residents with psychotropic medication orders monthly for the occurrence of GDR□s and send applicable requests to the appropriate physicians. The Pharmacist or designee will present the results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI	
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.	F 761		7/20/18

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F 761	Continued From page 31 §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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure medications were not expired in 1 of 3 medication storage areas (East Wing medication cart). The findings were: Observation on 6/14/18 at 9:30 AM of the East Wing medication cart revealed a Humalog insulin injection pen and a Lantus insulin injection pen were not labeled with an expiration date. Interview with RN #5 revealed the medications were for resident use and should have been labeled with an expiration date of 28 days after opening.	F 761	1. RN # 5 replaced and dated the new Humalog insulin injection pen and the Lantus insulin injection pen on the East Wing medication cart on 6/14/18. 2. The DON or designee will audit the 3 medication carts and the 2 medication rooms to ensure that no medications are expired and that expired medications are removed and replace appropriately. 3.The DON or designee will educate all staff on the appropriate monitoring and dating of medication expiration dates. The Staff Nurse will monitor the medication rooms and carts for expired medications with each assigned medication order night. 4.The DON or designee will audit the 3 medication carts and the 2 medication rooms monthly to ensure that no medications are expired and that expired medications are removed and replace appropriately. The DON or designee will present the	

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F 761	Continued From page 32	F 761	results of the audit at the QAPI meetings. The audits will continue until a goal of 90% for 3 consecutive quarters is obtained or until otherwise deemed necessary by the QAPI Committee.	