STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 02/14/2019

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	60 MAGNOLIA CASPER, WY 82604

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/11/19 through 2/14/19. Also reviewed in the course of the survey were complaint intakes WY00002685,WY00002764,WY00002767, and WY00002782. 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 LPN: Licensed Practical Nurse MDS: Minimum Data Set mg: Milligrams RD: Registered Dietitian 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	F 550		3/19/19

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

Electronically Signed 03/14/2019

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §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, staff and resident interview, and medical record review, the facility failed to ensure residents were treated in a dignified manner. This failure affected 1 of 17 sample residents (#152) interviewed about rights and dignity. The findings were: Review of the 1/9/19 admission MDS assessment showed Resident #152 had a BIMS score of 15/15 (cognitively intact), used a walker and	F 550	1. Resident 152 was offered to move to a different room due to being awakened while cares were provided to roommate. Resident 152's appointment was rescheduled and she was seen on 2/25/19. 2. All residents are at risk for being awakened due to noise in the facility and those with appointments outside the facility are at risk for being taken to a	

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F 550	Continued From page 2 wheelchair and was independent in activities of daily living. The following concerns regarding resident dignity were identified: a. Review of the 1/19/19 admission MDS assessment showed it was very important to the resident to choose his/her bedtime. Review of a Grievance/Concern Report Form dated 2/8/19 showed investigation, actions taken, and follow up were completed on 2/8/19 to address the resident's concern about staff being noisy when they provided early morning care for the roommate. Interview on 2/12/19 at 10:50 AM with the resident revealed s/he had a difficult time sleeping and once awake had problems getting back to sleep. The resident stated staff woke him/her early every morning when they made so much noise talking and providing care for the roommate. S/he stated s/he had talked with the manager about it and for a short period of time it stopped and then on 2/11/19, staff did it again. S/he further stated, "It makes me feel terrible to have to be awake when not ready to get up yet." b. Interview on 2/12/19 at 10:50 AM with the resident revealed the facility transported the resident to the physician's office for an appointment on 2/11/19 and the physician was not there. The resident stated s/he did not understand why someone did not tell him/her before leaving the facility, then s/he would not have gotten out in the cold weather and sat at the physician's office waiting for nothing. Interview on 2/14/19 at 11:15 AM with the administrator revealed the resident's appointment was canceled, but this information had not been communicated to the transporter or resident. The administrator also stated transporting residents to appointments, scheduling, and canceling was a problem she thought had been resolved when they changed the system to make the transporter	F 550	cancelled appointment. Education was provided at the time of survey to the staff members that were working to ensure they are quiet during the hours of sleep. A staff member was assigned to verify appointments the day prior to the appointment to avoid unnecessary transports. 3. Nursing staff will be educated by the DON no later than March 18, 2019 on keeping noise levels down during times of sleep and to do all they can to not disturb roommates during cares. Staff will be educated to report to the Unit Manager or DON any resident who has a complaint of being wakened in the night. Those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked. 4. The Director of Nursing (DON) or designee will interview five random residents each week to ensure the noise levels are night are minimal and will audit 5 random residents who are transported to a medical appointment to ensure there are no issues with their transportation/appointment. Audits will include cited resident number 152 and will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly Quality Assurance Process Improvement (QAPI) meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	

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F 550	Continued From page 3 responsible for confirming appointments the day before.	F 550		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the MDS 3.0 RAI (Resident Assessment Instrument) manual, the facility failed to ensure a significant change assessment was completed for 1 of 32 (#46) sample residents reviewed. The findings were: Review of the 12/7/18 quarterly MDS assessment showed resident #46 was admitted to the facility on 6/1/18. Further review of the medical record showed the resident was admitted to hospice on 11/26/18, and there was no evidence a significant change MDS assessment was completed. Interview with the MDS coordinator on 2/14/18 at 10:46 AM confirmed a significant change MDS assessment had not been completed after the resident was admitted to hospice.	F 637	1. Resident 46 has had a significant change assessment completed. 2. All residents are at risk for missed assessment when they receive orders for Hospice Care or experience other changes of condition. The IDT team will discuss any new Hospice patients each morning at the morning Quality Conference, as well as discuss any other changes of condition. 3. The MDS Coordinator is aware of the significant change requirements and was not aware of the resident's transition to Hospice care. Residents on Hospice care, as well as any other changes of condition, have been added to the morning quality start up meeting agenda to be discussed daily so that MDS	3/19/19

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F 637	Continued From page 4 Review of the CMS RAI version 3.0 Manual, October 2017, showed "03. Significant Change in Status Assessment (SCSA) (A0310A=04)...A SCSA is required when a terminally ill resident enrolls in a hospice program..."	F 637	coordinator is aware and can generate the appropriate significant change assessment. 4. The DON or designee will audit five residents each week to ensure resident has not had a significant change and require a significant change assessment. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the RAI (Resident Assessment Instrument) manual, the facility failed to ensure the accuracy of the MDS assessment for 1 of 32 sample residents (#101). The findings were: Review of the admission MDS assessment with an assessment reference date of 9/28/18 showed resident #101 was admitted to the facility on 9/21/18 with diagnoses which included diabetes mellitus and depression. The following concerns were identified: a. Review of the resident's medical record showed a recorded weight of 158.8 pounds on 10/28/18, and a recorded weight of 120.4 pounds	F 641	1. Resident 101's MDS for 9/28/18 was modified to include a documented weight during the assessment period. Resident's 1/4/19 MDS could not be modified as the facility does not have a documented weight during the 30-day lookback period. Resident has been weighed and such is recorded in the medical record. 2. All residents are at risk for missed weights. The MDS Coordinator will immediately report to the DON anytime she notes a weight is missing from the medical record while doing the MDS. Weights will be reviewed by the Interdisciplinary Team (IDT) each	3/19/19

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F 641	Continued From page 5 on 1/17/19 reflecting a 24.8% weight loss. Review of the entire medical record showed no evidence the weight loss was addressed. b. Review of the 9/28/18 admission MDS assessment and 1/4/19 quarterly MDS assessment showed the facility failed to document the required weight for each assessment. c. Interview with the RD on 2/13/19 at 4:14 PM confirmed the facility failed to document a weight on the MDS assessments for the resident. He further confirmed he was not made aware of the resident's weight loss, and his expectation of staff was that he and the charge nurse would be notified of a change in residents' weight. Review of the "CMS RAI version 3.0 manual, October 2018, showed"..."When completing the MDS 3.0, there are some items that require a count or measurement... For example, number of pressure ulcers, or weight."	F 641	morning, Monday through Friday, at the morning Quality Conference. 3. The MDS Coordinator was educated that weights must be recorded on the MDS and to report to the DON anytime there is not a weight in the medical record. Nursing staff will be educated that the resident must be weighed per physician order and/or RD recommendation and recorded in the medical record. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked 4. The DON or designee will audit five MDS each week to ensure the weight is recorded on the MDS. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	
F 645 SS=D	PASARR Screening for MD & ID 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	F 645		3/19/19

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F 645	Continued From page 6	F 645		

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 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

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F 645	Continued From page 7 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 a Preadmission Screening and Resident Review (PASARR) level I & II was performed for 1 of 2 sample residents (#40) with a qualifying diagnosis. The findings were: Review of the medical record for resident #40 showed the resident was admitted to the facility on 7/5/13 with a diagnosis of unspecified psychosis. Further review showed the resident received a diagnosis of major depressive disorder on 4/19/16. Further review showed no evidence a PASARR level I or PASARR level II was performed. Interview with the clinical director of operations on 2/14/19 at 8:55 AM revealed the facility was unable to find a completed PASARR level I or II for the resident.	F 645	1. No immediate correction can be made for resident□s missing PASARR. Resident passed away on 2/17/18. 2. All residents with a mental disorder or intellectual disability are at risk. The Admissions Coordinator, DON and Administrator/Assistant Administrator have been trained on the PASARR requirement. 3. Residents with new diagnosis or new psychotropic medication orders will be discussed by the IDT at each morning□s Quality Conference to ensure need for PASARR 4. The Administrator or designee will audit three residents each week to ensure a PASARR is completed as required. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly	

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F 645	Continued From page 8	F 645	QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	
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 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.	F 656		3/19/19

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F 656	Continued From page 9 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop a comprehensive person-centered care plan for 3 of 32 sample residents (#31, #46, #101) reviewed. The findings were: 1. Review of the 12/7/18 quarterly MDS assessment showed resident #46 received hospice services. Further review of the medical record showed the resident was admitted to hospice on 11/26/18. The following concerns were identified: a. Review of the care plan, last reviewed 1/3/19, showed no evidence a plan of care had been developed related to the hospice services received by the resident. b. Interview with the DON on 2/13/19 at 3:08 PM confirmed the care plan had not been fully developed. 2. Medical record review showed resident #31 was admitted to the facility on 8/31/17 with diagnoses which included dementia without behavioral disturbances, and depression. Interview on 2/13/19 at 8:46 AM with LPN #1 revealed the resident had an adaptive hearing device that s/he would sometimes use if another	F 656	1. Resident 31, 46 and 101's care plans have been updated. 2. All residents are at risk for missing interventions on their care plan. Changes or condition, such as weight loss or Hospice care will be discussed by the IDT at morning Quality Conference so that care plan updates are not missed. Staff have been educated to ensure plans of care are kept current to reflect the care that is provided. 3. All staff have been educated on the requirement to ensure plans of care are kept updated with the most current problems and interventions 4. The DON or designee will audit five random care plans each week to ensure the plan of care is current and will audit 5 random Hospice patients to ensure facility care plan and Hospice care plan are integrated. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 656	Continued From page 10 resident or visitor's voice was soft. Observation on 2/13/19 at 9:44 AM in the resident's room showed s/he had headphones for hearing assistance. The following concerns were identified: a. Review of the resident's care plan, last revised on 9/8/17, showed a plan for communication which included speaking louder. Further review showed the facility failed to address the resident's adaptive hearing device on the plan. b. Interview with the MDS Coordinator on 2/14/19 at 2:43 PM confirmed the resident's adaptive hearing device was not addressed on the care plan. 3. Review of the admission MDS assessment with an assessment reference date of 9/28/18 showed resident #101 was admitted to the facility on 9/21/18 with diagnoses which included diabetes mellitus and depression. Review of the Weights and Vitals Summary showed the resident weighed 158.8 pounds on 10/28/18 and 120.4 pounds on 1/17/19 (24.8% weight loss). The following concerns were identified: a. Review of the care plan showed the RD revised the plan on 1/9/19 to include, "Monitor weights monthly or as indicated." The plan failed to include what interventions were required of staff when the resident's weight was different than prior documented weights, or what weight difference would trigger an intervention. b. Interview with the RD on 2/13/19 at 4:14 PM confirmed he was not made aware of the resident's weight loss, and that his expectation of staff was that he and the charge nurse would be notified of a change in residents' weight.	F 656	5. March 19, 2019	
F 657	Care Plan Timing and Revision	F 657		3/19/19

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F 657 SS=D	Continued From page 11 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 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 and staff interview, the facility failed to ensure the comprehensive person-centered care plan was revised as needed to reflect the resident's current needs for 2 of 32 sample residents (#78, #135) reviewed. The findings were: 1. Review of the medical record for resident #78	F 657	1. Resident 78 care plans has been updated. Resident 135 has been discharged. 2. All residents are at risk for inaccurate code status listed on care plan. All residents were checked to ensure their code status was correct in PCC and on the care plan on 3/14/19. The Admission	

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F 657	Continued From page 12 showed s/he was admitted to the facility on 12/21/18. Further review of the medical record showed the resident had an advance directive dated 12/23/18 which indicated DNR (do not resuscitate). The following concerns were identified: a. Review of the resident's care plan, initiated 12/21/18, showed the resident had "full code status" and "staff will intervene appropriately if I should need cardiac resuscitation." 2. Review of the medical record for resident #135 showed s/he was admitted to the facility on 11/7/18. Further review of the medical record showed the resident had an advance directive dated 11/8/18 which indicated the resident had chosen to be resuscitated. The following concerns were identified: a. Review of the resident's care plan initiated 11/7/18 showed the resident had an advance directive of DNR/DNI (do not resuscitate/do not intubate) and "staff will provide comfort cares in a respectful manner." In addition the care plan stated the resident was "being admitted here for hospice care." 3. Interview with the DON on 2/13/19 at 3:12 PM confirmed the care plans were inaccurate and needed to be revised.	F 657	Coordinator or Social Service Department will notify the MDS Coordinator of any changes in the resident's code status so that the care plan can be updated. This will also be reviewed at the morning Quality Conference meeting. 3. The IDT has been educated on the importance of ensure code status is current in the plan of care. 4. The DON or designee will audit five random care plans each week to ensure code status is accurate on the plan on care. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course	F 661		3/19/19

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F 661	Continued From page 13 of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 1 residents (#157) reviewed for discharge to the community. The findings were: Review of the medical record for resident #157 showed s/he was admitted to the facility on 11/21/18 for rehabilitation. The resident was discharged to the community on 11/27/18. Further review showed no evidence a recapitulation of the resident's stay had been completed. Interview with the social worker on 2/14/19 at 2:41 PM verified the discharge summary was not	F 661	1. Resident 157□s discharge summary has been completed. 2. All residents that are discharged are at risk for not having a discharge summary completed. The IDT will discuss discharges at the morning Quality Conference and check to ensure a discharge summary has been completed. 3. The IDT has been educated on the discharge summary requirement. 4. The DON or designee will audit all discharges each week to ensure a discharge summary/recap has been completed. Audits will be weekly for four weeks and then monthly for two months.	

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F 661	Continued From page 14 complete.	F 661	Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and medical record review, the facility failed to ensure residents were offered meaningful and ongoing activities designed to improve or maintain physical, mental, and psycho-social well-being for 2 of 32 sample residents (#19, #70) reviewed for activities. The findings were: 1. Review of the quarterly MDS assessment dated 11/8/18 showed resident #19 had a BIMS score of 14/15 (cognitively intact). Review of the annual MDS assessment dated 2/8/18 showed it was "very important" for the resident to go outside to get fresh air when the weather was good, and to do his/her favorite activities. The following concerns were identified:	F 679	1. An out of facility activity has been scheduled and is on the Activity Calendar for March and two out of facility activities for April. Activities are added based on feedback from residents in Resident Council and by verbal suggestions from residents. Residents 19 and 70 were both invited to the outing and have been interviewed on activity choices. 2. All residents are at risk for not having activities of their preference offered. The Activity Coordinator will ask each resident about activity programming additions at their quarterly assessment and at care conferences. An activity suggestion box has been placed in the activity room and	3/19/19

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F 679	Continued From page 15 a. Interview with the resident on 2/12/19 at 8:46 AM revealed the facility did not have a lot of activities s/he was interested in. The resident said s/he previously participated in activities outside the facility. However, facility had only 1 functional van, and activities were no longer scheduled outside of the facility. Further, it was revealed if residents wanted to use local transportation to do activities outside of the facility, it cost money that some of them could not afford. 2. Review of the admission MDS assessment dated 12/24/18 showed resident #70 had a BIMS score of 14/15 (cognitively intact). Further review showed it was "very important" for the resident to go outside to get fresh air when the weather was good, and to do his/her favorite activities. Review of the resident's care plan showed his/her activity interests included arts & crafts, listening to music on the radio, and spending time outdoors. The following concerns were identified: a. Interview with the resident on 2/12/19 at 10:08 AM revealed s/he did not participate in activities; however, s/he would like to participate in activities outside of the facility. Further, it was revealed the resident was not aware of any activities outside of the facility that s/he could participate in. 3. Review of the activity calendar for January 2019 and February 2019 showed no evidence activities were scheduled outside of the facility. 4. Interview with the activities director on 2/14/19 at 9:07 AM revealed prior to the bus going out of service, the facility had outings for residents to participate in activities outside of the facility. She revealed she understood why residents would feel "trapped" and "like prisoners." Further	F 679	activities will continue to be discussed at monthly Resident Council. The Activity Coordinator will schedule at least one out of facility activity per month. 3. All staff have been educated on the importance of varying activities, including scheduled activities outside of the facility. 4. The Administrator or designee will audit Activity Programming to ensure out of the facility activities are offered at least monthly. Additionally, five random residents will be asked if activity programming is meeting their interest/needs. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at monthly QAPI meetings for recommendation for continuation or discontinuation of audits based on weekly/monthly audit results 5. March 19, 2019	

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F 679	Continued From page 16 interview revealed activities could perform outings in the evenings and on the weekends to allow residents to participate in activities outside of the facility.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure physician's orders were followed for 1 of 32 sample residents (#133) receiving medications. The findings were: Review of the care plan, revised 2/4/19, showed resident #133 had moderate cognitive impairment and required assistance with dressing, grooming, transfers, bed mobility, and toileting. Review of the 7/26/18 physician's orders showed an initial order for daily chewable Aspirin, 81 milligrams. Review of the medication administration record for January and February 2019 showed the physician repeated the order on 10/23/18. Further review showed additional instructions to make sure the Aspirin was chewable, because the resident was allergic to the coating on other formulations. The following concerns were identified:	F 684	1. Resident 133 is receiving the correct medication. Resident did not have any adverse outcomes from missing random doses of chewable aspirin. The facility is not aware of specific dates in which he was given the incorrect aspirin. The resident's physician is aware of this discrepancy. 2. All residents are at risk for receiving incorrect medications. Nurses and med aides will be educated on the medication administration policy. 3. The DON or designee will educate all nurses and med aides on the medication administration policy. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked.	3/19/19

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F 684	Continued From page 17 a. Interview on 2/12/19 at 1:53 PM with the resident revealed s/he was upset because the staff ignored his/ her protests and continued to administer Aspirin with coating. S/he stated the nurses repeatedly brought the medication to him/her, but s/he refused to take it due to an allergy to the outer coating. S/he further stated,"when they don't listen it makes you feel like you are nothing." S/he then removed a medication cup from the bedside stand drawer. Observation at that time showed 9 tablets were in the medication cup that the resident stated were enteric coated Aspirin. b. Review of the 2019 medication administration records showed staff documented they administered chewable Aspirin, 81 milligrams, every day as ordered. c. Interview on 2/13/19 at 9:45 AM, with RN #2 revealed she had to go to the medication storage area to get the chewable Aspirin that day because none were in the medication cart. At that time the RN revealed when she first became aware of this problem she started labeling the medication containers to help staff easily differentiate between the chewable and non-chewable Aspirin. She further stated she did not know it continued to be a problem. d. Interview on 2/14/19 at 10 AM with unit manager #1, when he observed the medications in the resident's bedside stand drawer, revealed he knew this was a problem, but did not know it had gotten that bad. He further stated most of the staff were aware of the specific order for chewable Aspirin, but some of the more recently employed staff were not familiar with the resident.	F 684	4. The DON or designee will audit five medication passes each week, including the cited resident #133, to ensure residents are getting the correct medications. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		3/19/19

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F 692	Continued From page 18 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and family interview, the facility failed to ensure an ongoing assessment was completed to implement adequate interventions to address weight concerns for 2 of 2 residents (#101, #126) identified with significant weight loss. This failure resulted in harm to both residents, whose loss of significant amounts of weight went unidentified by the facility. The findings were: 1. Medical record review showed resident #101 was admitted to the facility on 9/21/18 with diagnoses which included diabetes mellitus, depression, unspecified pain, unspecified gastrointestinal hemorrhage, and calculus of the	F 692	1. Resident 126 has been seen by her physician who noted weight loss was unavoidable and ordered comfort care. Resident did die on 3/13/19. Resident 101 has been assessed by the RD. The MD has been notified of weight loss and has been scheduled for the earliest available appointment with the physician. Resident weight loss interventions included in their plan of care. 2. All residents are at risk for weight loss. Discussion of resident weights/weight loss has been added to the morning Quality Conference so that missing weights or any weight loss can be reviewed and interventions put into place	

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F 692	Continued From page 19 gallbladder with acute cholecystitis without obstruction. The following concerns were identified: a. Review of the resident's recorded weights showed a weight of 158.8 pounds on 10/28/18, and a weight of 120.4 pounds on 1/17/19 (24.8% weight loss over approximately 3 months). b. Observation of the resident being placed in bed with a sit-to-stand lift on 2/13/19 at 1:23 PM showed the resident's pants were loose, and had to be adjusted to prevent them from falling off. At that time, the wound care nurse and a family member of the resident, who was also his/her power of attorney, stated the resident had been losing enough weight to need smaller pants. The resident's power of attorney also revealed the resident's pants were downsized in the last month already due to weight loss, though the resident ate well. The resident was observed during 2 meals during the survey, the 2/12/19 evening meal and the 2/13/19 noon meal, and no concerns with the resident's eating were identified. The resident required only set-up assistance during meals. c. Review of the 1/4/19 RD Nutrition Follow-up showed the area to notify the physician or nurse practitioner of a significant nutritional weight change was marked "not applicable (N/A)." Monthly weights, labs as available, and follow-up via MDS schedule were marked for interventions. No weight was documented, and the last weight documented in the medical record was 158.8 lbs on 10/28/19. d. Review of the care plan showed the RD revised the plan on 1/9/19 to include, "Monitor weights monthly or as indicated." The plan failed to include interventions that were required of staff when the resident's weight was different than prior documented weights, or what weight	F 692	3. The IDT has been educated to ensure missing weights and/or weight loss is reviewed and plans of care is put into place and Registered Dietician and physician are notified. Nursing staff will be educated that the resident must be weighed per physician order and recorded in the medical record. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked 4. The DON or designee will audit five residents to ensure any weight loss is addressed. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be discussed at monthly QAPI meetings for recommendation for continuation or discontinuation of audits based on weekly/monthly audit results. 5. March 19, 2019	

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F 692	Continued From page 20	F 692		

difference would trigger an intervention. Review of the entire medical record showed the resident's significant weight loss was not addressed.

d. Interview with the RD on 2/13/19 at 4:14 PM confirmed he was not made aware of the resident's weight loss and had not assessed the weight loss. He further stated his expectation of staff was that he and the charge nurse would be notified of a change in residents' weight.

2. Review of the quarterly MDS assessment dated 11/26/18 showed resident #126 had diagnoses which included pneumonia, urinary tract infection (UTI) in the last 30 days, and non-Alzheimer's dementia. The resident required supervision or cueing with setup help only for eating and had a weight loss of 5% in the last month or 10% in the last 6 months which was not physician prescribed. Review of the physician orders showed the resident was ordered "Boost" drinks 4 times per day for weight loss/health maintenance on 8/8/18. The following concerns were identified:

a. Review of the admission MDS assessment dated 8/11/18 showed the resident had a weight of 196 pounds and no weight loss was identified. Further review showed no nutritional interventions were implemented at that time.

b. Review of the weight summary dated 10/3/18 showed the resident weighed 181.2 pounds. Further review showed the resident's weight declined to 163.8 pounds on 11/9/18, 145.8 pounds on 12/3/18, 138.4 pounds on 1/18/19, and 130.4 pounds on 2/5/19. The weight loss from 10/3/18 to 2/5/19 was 50.8 pounds or 28% weight loss over approximately 4 months.

c. Interview with the RD on 2/13/19 at 3:45 PM revealed the resident had some recent hospitalizations and diagnoses and medications

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F 692	Continued From page 21 which had affected his/her weight. The dietitian confirmed the resident was ordered a supplement in August, and revealed s/he did not receive any dietary interventions until "a week or 2 ago" when a mechanical soft diet and small portions were implemented. Further, the dietitian confirmed no interventions were implemented in November or December and he "believed" the resident received assistance with meals related to the resident "not eating well."	F 692		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		3/19/19

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F 725	Continued From page 22 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, review of resident council meeting minutes, and review of facility staffing documentation, the facility failed to ensure an adequate number of staff was provided to meet resident needs on 4 of 5 units (East, South, Rapid Recovery, West). The findings were: Review of the proposed staffing sheets received from the DON on 2/13/19 showed the following: a. The East unit required 7 CNAs and 5 RNs, LPNs, and/or certified medication aides (MA-Cs) per day. The minimum PPD (per patient day) for CNAs was 80.5 hours, and 60 hours for nurses and/or MA-Cs. b. The South unit required 7 CNAs and 5 nurses per day. The minimum PPD for CNAs was 80.5 hours, and 48 hours for nurses and MA-Cs, with an increase to 60 hours when the census rose to 45 residents. c. The Rapid Recovery unit required 4 to 7 CNAs according to census, and 2 to 5 nurses and/or MA-Cs according to census. The minimum PPD for CNAs was 46 hours with a maximum of 80.5 hours according to census. The minimum PPD for nurses and/or MA-Cs was 24 hours with a maximum of 60 hours according to census. d. The West unit required a minimum of 2 CNAs with a maximum of 5 CNAs according to census, and 2 nurses or MA-Cs. The minimum PPD for CNAs was 46 hours with a maximum of 57.5 hours according to census. The nursing and/or MA-C PPD requirement was 24 hours. The following concerns were identified:	F 725	1. No immediate correction can be made for past low staffing levels. Residents are receiving the needed care. A CNA meeting was held to discuss staffing and gather ideas for scheduling. As a result, a new schedule was developed for staff to work 40 hours instead of the current 36 hours, will include 8 hour shifts and will add additional 4 hour shifts during heavy care times. The schedule will be fully implemented by May 1, 2019. Additional pick up bonuses are offered as needed when staffing levels dictate. 2. All residents are at risk for gaps in care due to low staffing levels. The facility has an active recruitment and retention program and interviews each qualified applicant. The facility has hired five new CNAs that have started at the facility and have four CNAs pending background check. Additionally, the facility has advertised for unlicensed assistive personnel and will hire until such time the facility can send them to a community nurse aide training program. The facility is currently interviewing applicants at this time. Additionally, the IDT meets daily, Monday through Friday, to discuss staffing and plan for coverage. 3. Nursing staff will be educated by the DON about changes in scheduling and recruitment bonuses and should they feel that they can't provide the required care to residents, they should immediately notify	

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F 725	Continued From page 23 1. Concerns from resident council meetings: a. Review of the December 2018 and January 2019 resident council meeting minutes showed residents were concerned about night shift staffing and a delay in staff responding to call lights. b. During a 2/12/19 resident council meeting, the residents said the facility did not have enough staff in the dietary department to serve meals timely. The resident's differed on the time it took to serve. Some residents reported waiting 45 minutes or longer. The residents stated staff treated them well and tried very hard; however, there was not enough staff and staff were tired. Some residents felt staffing was worse during the night and others felt there were problems during all shifts. 2. Concerns from resident interviews: a. Interview with resident #104 on 2/12/19 at 9:42 AM revealed the facility did not have enough staff. S/he stated call lights went unanswered for 30 or more minutes. b. Interview with resident #66 on 2/11/19 at 2:35 PM revealed staff sometimes took between 30 minutes and one hour to answer call lights and staff sometimes verbalized the facility was short staffed. c. Interview with resident #44 on 2/11/19 at 3:36 PM revealed there was insufficient staff on most days which resulted in a delay for his/her personal care. d. Interview with resident #112 on 2/11/19 at 3:04 PM revealed it took almost an hour to answer call lights and staff stated they were short of help. S/he stated this issue was particularly bad after the evening meal. e. Interview with resident #127 on 2/12/19 at 1:41 PM revealed staff did not answer call lights	F 725	the Unit Manager or DON so that additional resources can be deployed as needed. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked 4. The Administrator or designee will audit five random shifts each week to ensure staffing levels are appropriate on each unit. Additionally, five random residents will be interviewed regarding call light response time, as well as, observation of call light response time. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	

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in a timely manner. The resident stated s/he sometimes waited 90 minutes.

3. Concerns from staff interviews:

a. Interview with CNA #7 on 2/14/19 at 11:24 AM revealed residents often did not get showers because of staffing. The residents went over a week without showers. The facility expected all missed showers to be made up in 1 day so they had to shower 20 residents in one day. The residents were neglected by staff, not by choice, but because of the lack of staff. Staff had 9 hours to get 20 residents showered and had to spend 15 minutes cleaning the room after showers which resulted in "about 5 minutes" for a shower for each resident which included shaving, dressing, and the shower itself. Further she stated it took longer to answer call lights, which rushed care for the residents.

b. Interview with CNA #3 on 2/14/19 at 11:29 AM revealed the facility had only 1 shower aide the previous week, and only one shower aide on some other weeks. S/he stated the facility continued to lose a lot of staff because "everyone is really tired."

c. Interview at 2/12/19 at 10:36 PM with CNA #4 revealed there was not enough staff to get things done timely which included putting residents to bed, changing residents who were incontinent, toileting residents, answering call lights, etc. S/he stated some residents became irritated with us for the lack of timeliness concerning their care.

d. Interview on 2/14/19 between 11:10 AM and 3:25 PM with CNA #2 revealed showers did not get done when the facility was short of staff, and it took two staff to transfer residents who required the use of a mechanical lift for transfer.

e. Interview on 2/14/19 between 11:10 AM

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and 3:25 PM with CNA #5 revealed due to a shortage of staff, weights and charting got missed, and bed linens were not changed in a timely manner.

f. Interview on 2/14/19 between 11:10 AM and 3:25 PM with CNA #6 revealed the facility sometimes had to pull the shower aide away from shower duty and reassign the aide to a floor assignment due to a shortage of staff.

g. Interview on 2/14/19 between 11:10 AM and 3:25 PM with housekeeping staff member #1 revealed not all rooms were cleaned daily when the facility was short of staff.

h. Interview on 2/14/19 at 3:40 PM with the housekeeping and laundry supervisor confirmed the facility had 3 open positions in housekeeping and laundry.

4. Concerns from facility staffing documentation:

a. Review of the facility staffing sheets for 1/1/19 through 1/31/19 revealed the East unit failed to have the minimum required CNA staffing on 21 of the 31 days (68%). In addition, the East unit failed to have the minimum required nursing and/or MA-C staffing on 18 of 31 days (58%). Review of the facility staffing sheets for 2/1/19 through 2/14/19 revealed the East unit failed to have the minimum required CNA staffing for all 14 days. In addition, the East unit failed to have the minimum required nursing and/or MA-C staffing on 9 of 14 days (64%).

b. Review of the facility staffing sheets for 1/1/19 through 1/31/19 revealed the South unit failed to have the minimum required CNA staffing on 26 of the 31 days (84%). In addition, the South unit failed to have the minimum required nursing and/or MA-C staffing on all 31 days. Review of the facility staffing sheets for 2/1/19 through 2/14/19 revealed the South unit failed to have the

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F 725	Continued From page 26 minimum required CNA staffing for 13 of 14 days (93%). In addition, the South unit failed to have the minimum required nursing and/or MA-C staffing on all 14 days. c. Review of the facility staffing sheets for 1/1/19 through 1/31/19 revealed the Rapid Recovery unit failed to have the minimum required CNA staffing on 28 of the 31 days (90%). In addition, the Rapid Recovery unit failed to have the minimum required nursing and/or MA-C staffing on 27 of 31 days (87%). Review of the facility staffing sheets for 2/1/19 through 2/14/19 revealed the Rapid Recovery unit failed to have the minimum required CNA staffing for all 14 days. In addition, the Rapid Recovery unit failed to have the minimum required nursing and/or MA-C staffing on 10 of 14 days (71%). d. Review of the facility staffing sheets for 1/1/19 through 1/31/19 revealed the West unit failed to have the minimum required CNA staffing on all 31 days. Review of the facility staffing sheets for 2/1/19 through 2/14/19 revealed the West unit failed to have the minimum required CNA staffing for all 14 days. 5. Interview with the administrator on 2/14/19 at 2:45 PM revealed the facility was utilizing a staffing agency to fill empty positions for nurses. She stated the facility had 8 open nursing positions and 7 open CNA positions. She further stated staffing issues were a problem because of scheduling.	F 725		
F 756 SS=D	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	F 756		3/19/19

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F 756	Continued From page 27 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 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, pharmacy drug regimen review, facility policy review, and staff interview, the facility failed to ensure pharmacist	F 756	1. Resident 10 and Resident 96's physician has addressed the pharmacist recommendation.	

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F 756	Continued From page 28 recommendations were addressed for 2 of 5 sample residents (#10, #96) reviewed for medication regimen review. The findings were: 1. Review of the 11/2/18 quarterly MDS assessment for resident #10 showed s/he was admitted to the facility on 7/30/18. Review of the most current physician orders showed the resident was prescribed Abilify (antipsychotic) 2 mg daily and 4 mg at bedtime for dementia with Lewy bodies. The following concerns were identified: a. Review of the 2/12/19 pharmacist Consultation Report showed a "REPEATED RECOMMENDATION from 1/21/19" which stated the resident's Abilify was due for a GDR (gradual dose reduction) and to consider a small dose reduction or provide a statement addressing the risks/benefits of ongoing therapy. Review of the medical record revealed the recommendation had not been addressed. 2. Review of the 12/14/18 quarterly MDS assessment showed resident #96 was admitted to the facility on 4/3/15 and had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, depression, and psychotic disorder. Review of the most current physician orders showed the resident was prescribed lorazepam (antianxiety) 0.5 mg 3 times daily for anxiety/agitation with a start date of 1/7/19; lorazepam 0.5 mg as needed for anxiety/agitation with a start date of 1/7/19; quetiapine fumarate (antipsychotic) 50 mg 3 times daily for dementia with behavioral disturbances with a start date of 3/14/16; sertraline HCl (antidepressant) 25mg daily for depressive disorder with a start date of 12/7/18. The following concerns were identified: a. Review of the medical record for resident	F 756	2. All residents are at risk for not having pharmacist recommendations addressed by their physician. The DON will be process owner for pharmacist recommendations and will ensure recommendations are sent to MD and the facility receives follow up. 3. The new DON met with the new consultant pharmacist on March 13th as the facility changed pharmacy providers on March 1, 2019. The process for ensuring pharmacist recommendation was reviewed. The DON will fax recommendations to the MD and track their return and then will scan the returned recommendations back to the pharmacist for review. 4. The DON or designee will audit five residents each week to ensure Pharmacy recommendations and GDRs sent to MD are received back from the MD and are scanned into the electronic health record. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	

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#96 showed no evidence a monthly medication review (MRR) by a pharmacist had been completed. Documentation of the MRR was requested from the facility and received on 2/14/19 at 11 AM. At that time the DON verified the report had been emailed to her from the consultant pharmacist.

b. Review of the 2/12/19 pharmacist Consultation Report showed a "REPEATED RECOMMENDATION from 1/21/19" which stated the resident's quetiapine fumarate and sertraline were due for a GDR (gradual dose reduction) and to consider a small dose reduction or provide a statement addressing the risks/benefits of ongoing therapy. Review of the medical record revealed the recommendation had not been addressed.

3. Interview with the DON on 2/14/19 at 10:39 AM revealed it was her expectation the pharmacist's recommendations be dispersed to the unit managers and then to the physician. In addition, if the physician did not respond, the unit managers should either re-fax the recommendation or call the physician.

4. Review of the Medication Regimen Review policy last revised 11/28/16 revealed:

a. "7.1. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR, or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected."

b. "7.2. The attending physician should document in the residents' health record that the identified irregularity has been reviewed and

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F 756	Continued From page 30 what, if any, action has been taken to address it." c. "7.2.1. If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record." d. "11. The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident..." e. "12. Facility should maintain readily available copies of MRRs on file in Facility as part of the resident's permanent health record."	F 756		
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 (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	F 758		3/19/19

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F 758	Continued From page 31 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 review of policy and procedure, the facility failed to ensure PRN orders for psychotropic drugs did not extend beyond 14 days for 4 of 8 sample residents (#38, #88, #96, #134) reviewed for psychotropic medications and further, failed to ensure residents received a gradual dose reduction unless clinically contraindicated for 2 of 8 sample residents (#96, #104) reviewed for psychotropic medications. The findings were: 1. Review of the 12/14/18 quarterly MDS assessment showed resident #96 was admitted	F 758	1. Resident 38, 88, 96 and 134's provider has reviewed their psychotropic medications and they are no longer receiving PRN medications extending beyond 14 days. Resident 96 and 104 have had their physician address the GDR request from pharmacist. 2. All who take psychotropic medications are at risk for unnecessary medications. The IDT will discuss any new orders received for psychotropic medication in the morning Quality Conference so that any as needed medications do not exceed	

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F 758	Continued From page 32 to the facility on 4/3/15 and had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, depression, and psychotic disorder. Further review showed the resident had a BIMS score of 4/15 (severe cognitive impairment) and exhibited verbal behaviors and wandering daily during the 7-day look-back period. Review of the most current physician orders showed the resident was prescribed lorazepam (antianxiety) 0.5 mg 3 times daily for anxiety/agitation with a start date of 1/7/19; lorazepam 0.5 mg as needed for anxiety/agitation with a start date of 1/7/19; quetiapine fumarate (antipsychotic) 50 mg 3 times daily for dementia with behavioral disturbances with a start date of 3/14/16; and sertraline hydrochloride (antidepressant) 25 mg daily for depressive disorder with a start date of 12/7/18. The following concerns were identified: a. Review of the current physician orders showed the resident was prescribed lorazepam 0.5 mg as needed for anxiety/agitation on 1/7/19. Further review of the orders showed a stop date had not been included in the order or a rationale for extending the use beyond 14 days. Review of the January and February 2019 MAR (medication administration record) showed the resident received the medication 2 times in January and zero times in February. b. Review of the medical record showed the most current GDR request for quetiapine was declined by the physician on 1/22/18 with the rationale of "patient stable". c. Review of the 2/12/19 pharmacist Consultation Report showed a "REPEATED RECOMMENDATION from 1/21/19" which stated the resident's quetiapine fumarate was due for a GDR (gradual dose reduction) and to consider a small dose reduction or provide a statement addressing the risks/benefits of ongoing therapy.	F 758	14 days. 3. Nursing staff will be educated that the residents should not have prn psychotropic orders that extend greater than 14 days without physician review if medication needs to be continued. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked. The new DON met with the new consultant pharmacist on March 13th as the facility changed pharmacy providers on March 1, 2019. The process for ensuring pharmacist recommendations, including prn and gradual dose reduction recommendations was reviewed. The DON will fax recommendations to the MD and track their return and then will scan the returned recommendations back to the pharmacist for review. 4. The DON or designee will audit five residents each week to ensure prn medications do not exceed 14 days without further physician intervention. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	

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F 758	Continued From page 33	F 758		

Review of the medical record revealed the recommendation had not been addressed.

d. Interview with the DON on 2/14/19 at 10:44 AM revealed the pharmacist sent out the recommendations for GDRs when they were due. Further, the resident was transitioning between physicians. At that time the DON verified the physician order for the lorazepam did not have a stop date and a GDR or a risk/benefit statement had not been attempted in the last 12 months.

2. Review of a physician order dated 2/4/19 showed resident #134 was ordered lorazepam 1 mg by mouth three times per day as needed. The medication was ordered for 90 tablets or 30 days worth. Further review showed there was no evidence of a stop date for the medication or evaluation of appropriateness for the medication.

3. Review of the 4/13/15 physician's orders for resident #38 showed orders to administer Xanax 0.25 milligrams (anti-anxiety medication), give 0.25 milligrams by mouth every 6 hours as needed for agitation related to anxiety states. Review of the medication administration records for Nov 2018 and Dec 2018 showed the resident received 2 doses each month, received 1 dose in January 2019 and none in February 2019. Review of the pharmacy consultation reports dated 10/1/18, 11/5/18, 12/3/18, and 1/7/19 showed the pharmacist recommended this medication be limited to 14 days, unless the prescriber documented the diagnosed specific condition. This review showed no evidence of a response from the physician.

4. Review of the physician's orders showed resident #88 started receiving trazodone hydrochloride 25 milligrams PRN (as needed) on

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F 758	Continued From page 34 12/20/18 for insomnia/anxiety. Review of the MAR for January 2019 showed the resident received the medication on 13 of 31 days, and in February 2019 received it on 6 days of 11. Review of the 2/4/19 pharmacy consultation report showed a recommendation for the physician to review and respond because the PRN order for antidepressant, "...which had been in place for greater than 14 days if cannot be discontinued, the prescriber should document the indication for use, intended duration of therapy and rationale for the extended time period." Review of the 2/12/19 physician response showed the response was to decline the recommendation with no additional documentation regarding the rationale for continued use, indications, and duration. 5. Review of the pharmacy 1/7/19 consultation report showed resident #104 was due for a gradual dose reduction in daily doses of duloxetine (antidepressant) on 2/4/19. Review of the physician response showed the physician wanted the medication to remain unchanged, but a rationale for continued use was not documented. 6. Review of the policy titled "Psychotropic Medication Use" last revised on 12/1/16 showed "...PRN orders for psychotropic drugs should be limited to 14 days. 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..."	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		3/19/19

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F 804	Continued From page 35 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, review of posted meal times, review of resident council meeting minutes, review of grievances, and review of recipes, the facility failed to ensure the food was palatable during 1 of 1 food service observation. The findings were: Review of the posted meal times for the South dining room showed the meal would be served from 11:30 AM to 1:30 PM. Review of the menu for the noon meal on 2/13/19 showed the main meal consisted of balsamic glazed pork loin, sauteed zucchini, garlic and rosemary roasted red skin potatoes, dinner roll/bread, and scalloped apples. The alternate meal was Swedish meatballs, broccoli florets, and parsley herbed noodles. The following concerns were identified: a. Interview with a group of 10 residents on 2/12/19 at 3:36 PM revealed the food was not palatable. b. Review of the 12/5/18 resident council minutes showed a new concern of "food is poor" with no form completed to ensure follow-up of the concern. c. Individual interviews during the survey timeframe with 6 residents revealed comments of	F 804	1. Residents are served palatable food and the faulty equipment has been repaired or replaced to aid in proper cooking and holding of food. 2. All residents are at risk to be served unpalatable food. The tilt skillet has been repaired and a new holding oven was ordered and has been installed. Additionally, the facility will have a food council monthly that will include residents who discuss meals and any meal related improvement ideas. 3. Dietary staff will be educated by the RD or designee on plating food, which includes ensuring food is cooked per menu/directions. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked 4. The Administrator or designee will ask five random residents about meal service and palatability of the food. Additionally, the Administrator will request a test tray at least once weekly on a random day and random meal to test for palatability.	

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F 804	Continued From page 36 "food not good", "quality is poor", "food is dry", "the food is bland with no flavor", "the food could be better" and the "facility changed food suppliers and it isn't good, with a menu with no variety and nothing new offered." d. Review of a grievance filed with the facility on 12/16/18 revealed the food was "...still inedible. Meals served on a daily basis lacks flavor and seasoning...The person or persons who changed food companies did so without resident's best interest in mind..." The response from the facility dated 12/17/18 showed "resident continues to complain about the same things. Disgruntled from a year ago. Offered several options from always available menu. Still unsatisfied. Residents [spouse] brings meals in for [the resident]..." e. Observation of the meal preparation on 2/13/19 at 10:22 AM showed zucchini being cooked in a tilt skillet. At 10:45 AM the zucchini was transferred to a serving pan and put in a holding oven. At 11:02 AM the food was transferred to a cart and taken to the South dining room. f. A test tray with the contracted district manager on 2/13/19 at 12:22 PM in the South dining room revealed the zucchini was mushy, colorless, and bland; the brussel sprouts (substitution for broccoli) were mushy; the balsamic pork was dry, and the Swedish meatballs were bland. Interview with the district manager at that time revealed the zucchini was frozen and cooked with butter according to the recipe. Further, he stated squash will deteriorate quickly when sitting and being agitated by the serving utensils; making it hard to maintain. The district manager confirmed the zucchini was mushy and would reevaluate the cooking method for vegetables.	F 804	Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at monthly QAPI meetings for recommendation for continuation or discontinuation of audits based on weekly/monthly audit results. 5. March 19, 2019	

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F 804	Continued From page 37 g. Review of the zucchini recipe showed 25 pounds of frozen sliced zucchini was to be sauteed in one cup of oil until done. h. Interview with the certified dietary manager on 2/13/19 at 4:45 PM stated the tilt skillet used for preparing/cooking the zucchini did not work properly with the heat going off and on. During a later interview on 2/14/19 at 1:50 PM the dietary manager confirmed there were challenges with equipment maintenance which may have contributed to why the zucchini was overcooked and mushy. She also stated there had been a lot of grievances from the residents about the food since the contracted dietary company took over in November 2017.	F 804		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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	F 812		3/19/19

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F 812	Continued From page 38 by: Based on observation, staff interview, product label review, and review of the 2017 food code, the facility failed to ensure proper dating and labeling of pre-thickened beverage products in 4 of 4 dining areas (Rapid Recovery, East, West, South). In addition the facility failed to ensure outdated pre-thickened beverage products were discarded in 2 of 4 dining areas (Rapid Recovery and South). The findings were: 1. Observation on 2/14/19 at 8:34 AM of the Rapid Recovery dining room refrigerator showed 1 of 2 open cartons of pre-thickened beverage products was not labeled with an open date. In addition one carton available for resident consumption had a manufacturer's use by date of 1/28/19. 2. Observation on 2/14/19 at 8:42 AM of the East dining room refrigerator showed 1 open carton of pre-thickened beverage product was not labeled with an open date. 3. Observation on 2/14/19 at 8:50 AM of the South dining room refrigerator showed 7 of 18 cartons of pre-thickened beverage product were open and not labeled with an open date. In addition 3 cartons available for resident consumption had manufacturer's use by dates of 11/5/18, 12/10/18, and 12/11/18. 4. Observation on 2/14/19 at 8:55 AM of the West dining room refrigerator showed 2 of 2 open cartons of pre-thickened beverage product were not labeled with an open date. 5. Interview and observation of the South dining room refrigerator with the certified dietary	F 812	1. The opened, undated, and outdated cartons pre-thickened beverage was discarded at the time of discovery. 2. All residents are at risk to be served undated or outdated food or drink items. Dietary staff will check satellite fridges and food storage areas daily to ensure opened items are dated and there is no items stored past their use by date. 3. All Dietary staff will receive a labeling and dating in-service and nursing staff will be educated that all items opened must be dated. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked 4. The Dietary Manager or designee will audit storage areas, fridges and freezers to ensure there are no outdated items and that all opened items have an open date. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at monthly QAPI meetings for recommendation for continuation or discontinuation of audits based on weekly/monthly audit results. 5. March 19, 2019	

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F 812	Continued From page 39 manager on 2/14/19 at 1:50 PM confirmed the 3 cartons of pre-thickened liquids identified were beyond the manufacturer's use by date and the open cartons were not labeled with with an open date. In addition the certified dietary manager stated monitoring of the dining room refrigerators had been overlooked. 6. According to Food Code 2017, U.S. Public Health Service: 3-501.17 "(A)...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 5ºC (41ºF) or less for a maximum of 7 days."	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, and review of compliance history information, the facility failed to ensure an effective quality assessment and assurance (QAA) program was implemented to prevent repeat deficiencies (F353/F725) from previous surveys. The findings were: 1. Review of the Casper 3 report last updated on	F 867	1. No immediate correction can be made for repeated citations in staffing. All survey tags and audits were discussed in QAPI held on March 19th, 2019. A PIP was started for recruitment and Retention to address staffing. Continued audits will be reviewed monthly to ensure ongoing compliance.	3/19/19

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F 867	Continued From page 40 2/6/19 showed on the 2014, 2015, and 2017 recertification surveys the facility was cited for insufficient staffing (F353/F725). In addition the facility was cited for insufficient staffing on complaint surveys conducted on 6/20/18 and 7/25/18. The facility had corrected the identified deficient practice from the surveys. However, the facility was again cited with non-compliance of this issue on the 2/14/19 survey. 2. Interview with the administrator on 2/14/19 at 3:33 PM revealed staffing was not currently being monitored by the QAA committee.	F 867	2. All residents are at risk for gaps in care due to low staffing levels. The facility has an active recruitment and retention program and interviews each qualified applicant. The facility has advertised for unlicensed assistive personnel and will hire until such time the facility can send them to a community nurse aide training program. Additionally, the IDT meets daily, Monday through Friday, to discuss staffing and plan for coverage 3. The Divisional Director of Clinical Operations (DDCO) has educated the IDT on ensuring survey citations are monitored in QAPI and audits or other course corrections are taken as needed when an area is found to be out of compliance. 4. The DDCO will attend the facility QAPI meetings for the next three months to ensure discussion of survey citations and corrections. 5. March 19, 2019	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		3/19/19

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F 880	Continued From page 41 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 42 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and infection prevention program review, the facility failed to establish an infection prevention and control program which included a system to identify, report, investigate, and prevent infections. The census was 163. The findings were: Review of the infection prevention program on 2/14/19 at 3:57 PM showed the facility had documented residents on antibiotic therapy; however, there was no evidence of infection symptom monitoring, tracking and trending, or identification noted. Interview with clinical operations director at that time revealed the previous infection preventionist was doing the line listings; however, due to staff turnover the infection prevention program was not adequately in place at that time.	F 880	1. No immediate correction can be made for missing infection control line listing. A line listing was started effective March 1, 2019 for residents on antibiotics/current infections. 2. All residents are at risk for unidentified infections and symptom monitoring. The facility has named a nurse to assume duties as the Infection Control Nurse. 3. The DON and Infection Control Nurse have been educated on the infection control program requirements on 3/12/19. 4. The DON or designee will audit the line listing report three times a week to ensure all antibiotic use and symptom monitoring is in place. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	

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F 881	Continued From page 43	F 881		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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 medical record review, resident and staff interview, and infection prevention program review, the facility failed to establish an infection prevention and control program with antibiotic use protocols and a system to monitor antibiotic use. The census was 163. The findings were: 1. Review of the infection prevention program on 2/14/19 at 3:57 PM showed the facility had documented residents on antibiotic therapy; however, there was no evidence of infection symptom monitoring, tracking and trending, or identification noted. 2. Interview with resident #92 on 2/11/19 at 5:49 PM revealed the resident was on antibiotic therapy for a urinary tract infection (UTI). Review of a urine culture received on 1/18/19 showed the specimen was collected on 1/17/19, the resident's urine grew the bacteria Proteus mirabilis (a gram negative rod), and the sensitivity indicated the bacteria was resistant to nitrofurantoin (antibiotic). Further review showed a handwritten note for cephalexin (Keflex) (antibiotic) 500 mg by mouth twice per day for 7 days. Review of an "antibiotic	F 881	1. No immediate correction can be made for resident 92's administration of a medication that showed resistance on the urine culture lab report. The resident's MD was aware of the ineffective antibiotic as he was the one who changed the antibiotic after reviewing the lab report. The situation was also discussed at QAPI on March 19th, 2019 as the resident's physician, the facility's Medical Director, was in attendance. An antibiotic use report was reviewed to ensure no other residents were affected. Resident is free from infection. 2. All residents are at risk for receiving medications that are not effective. The facility has appointed an Infection Control nurse who will monitor all lab cultures to ensure there are not any medications given when the sensitivity shows resistance to that medication. 3. Nursing staff will be educated about culture reports and when they are received from lab they need to review to ensure the medication is appropriate. The	3/19/19

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F 881	Continued From page 44 time out review" entry dated 1/19/19 and timed 1:49 AM showed the resident was ordered cephalexin 500 mg by mouth twice per day for 7 days for a UTI. The following concerns were identified: a. Review of the "nurses notes" entry dated 1/29/19 showed "...Resident complained of pain over [his/her] lower abdomen. [S/he] asked if [his/her] Keflex was over. [S/he] reports I feel still have a UTI. Resident requesting to have [his/her] urine rechecked for a UTI..." b. Review of a "MD/NP/PA Note" dated 1/31/19 and timed 3:23 PM showed "...Patient presents today with concerns about bladder pain. [S/he] reports that [s/he] finished taking antibiotics for a UTI on the 25th and 1 to 2 days later develop [sic] symptoms again. Denies fevers or chills. Denies nausea or vomiting. Reports [s/he] just continues to have pain in [his/her] bladder and urethra...Labs:: Pending labs will be reviewed..." c. Review of a urine culture received on 2/1/19 showed the specimen was collected on 1/31/19 and the resident grew bacteria that was identified as "gram negative rods." The sensitivity had not been performed at that time. A handwritten note on the lab indicated an order for Macrobid (nitrofurantoin) 100 mg by mouth twice per day for 7 days. d. Review of a urine culture received on 2/2/19 showed the specimen was collected on 1/31/19 and the resident's urine grew the bacteria Proteus mirabilis. The sensitivity indicated the bacteria was resistant to nitrofurantoin. Further review showed a handwritten note to discontinue the Macrobid and start amoxicillin 875 mg by mouth twice per day for 7 days. 2. Interview with the clinical operations director on	F 881	Infection Control nurse will ensure culture results are sent to the physician timely and that facility receives a timely response to the reports. Education will occur no later than March 18th, 2019 and those not in attendance at education session due to illness, vacation, illness or casual work status will be educated prior to first shift worked 4. The DON or designee will audit three lab cultures each week to ensure antibiotic is appropriate after culture results and that MD has reviewed and responded timely to culture results. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5. March 19, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 45 2/14/19 at 3:57 PM revealed the nurses should have evaluated the labs and the antibiotic order to ensure appropriate antibiotics were used. Further interview revealed she thought if the facility had a trained person looking at antibiotic use they would have identified the gram negative rods might be Proteus mirabilis which was resistant to nitrofurantoin on the previous urine culture and the resident would not have received the medication.	F 881		