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	53A002	A. BUILDING _____ B. WING _____	C 05/20/2019

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 5/13/19 through 5/20/19. Also reviewed in the course of the survey were complaint intakes WY00002642 and WY00002828. DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse CNA: Certified Nursing Assistant MA-C: Certified Medication Aide Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §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	F 550		7/4/19

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

Electronically Signed | 06/11/2019

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F 550	Continued From page 1 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, medical record review, staff interview, facility incident review, and review of policy and procedure, the facility failed to ensure residents were treated with dignity and respect for 1 of 14 sample residents (#27). The findings were: 1. Observation on 5/13/19 at 5:28 PM showed resident #27 was in the dining room yelling at staff and crying. Review of the 3/18/19 significant change MDS assessment showed the resident had diagnoses which included non-Alzheimer's dementia and anxiety disorder. Further review showed the resident had a brief interview for mental status (BIMS) score of 5 (severe cognitive impairment) and required extensive or total assistance of 1 person for bed mobility, transfer, dressing, eating, toilet use, and personal hygiene.	F 550	The facility will ensure that resident are treated with dignity and respect. A)The allegation of 5/9/19 involving resident #27 was reported and investigated per protocol. On 5/13/19 the involved CNA was counseled by the facility administrator and DON re: expectations that employees demonstrate patience and kindness with residents, regardless of their behavior. Nurses assigned to resident #27's floor will observe staff interaction with this resident and intervene immediately if this resident is not being treated with dignity and respect. B)All residents are at risk for not being	

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F 550	Continued From page 2 Review of the resident's care plan received from the facility on 5/15/19 showed a problem area titled "communication...Hearing Deficit, understanding, being understood," a problem area titled "Psychotropic drug use" which included the intervention "...monitor for behaviors of yelling out, demanding, restlessness, irritation, foul language, agitation, or sadness and crying", and a problem area titled "Behavior" which included the intervention "Ask [resident's name] to please not yell as it is disruptive to others ..." The following concerns were identified: a. Review of the facility incidents showed an allegation of verbal abuse involving CNA #1 and the resident on 5/9/19. The allegation showed the resident was "yelling out in the dining room" and CNA #1 told the resident to "stop yelling," "she was tired of how [the resident] was treating her, calling her names and yelling and being rude all night." Further review showed the resident began to cry and the CNA stated "[the resident] shouldn't cry since [the CNA] wasn't crying." The CNA's tone was described as "harsh." b. Interview with MA-C #1 on 5/20/19 at 4 PM confirmed the CNA's tone during the alleged incident was "harsh." Further interview revealed the MA-C said the CNA's tone was "not pleasant" as she "raised her voice" and it was not authoritative; however, the MA-C was not able to demonstrate the CNA's tone. c. Interview with CNA #1 on 5/20/19 at 4:07 PM revealed on the day of the incident she was tired and "lost her grip." The CNA stated "everyone" thinks she "talks like she is mad" and on that day she told the resident "stop yelling and have patience." The CNA confirmed she raised her voice and told the resident to "stop cussing" and to "stop crying." d. Review of the policy titled "Philosophy of	F 550	treated with dignity and respect. Supervising nurses will observe staff interaction with various residents, including those that have been identified on MDS as having behavioral symptoms, at least 6 times per month. All staff will be reminded of the importance of immediately reporting any mistreatment of any resident to the Supervising Nurse for appropriate follow up. C)MSS will educate all facility staff on treating residents with dignity and respect; guidance will be offered on how to handle frustration during difficult situations. D)A performance improvement tool will be developed by the DON to monitor that residents are being treated with dignity and respect and that any issues are dealt with appropriately. This will be completed monthly and include at least 6 observations per month. It will be reviewed quarterly by the QAPI committee.	

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F 550	Continued From page 3 Care Center" last reviewed on 6/2017 showed "...Our residents are encouraged to work to help the facility become their new home. They are treated with respect, dignity, and allowed choices and a voice in their personal care..."	F 550		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record review, the facility failed to consistently provide restorative nursing care for 5 of 10 sample residents (#10, #27, #28, #37, #40) who required this care to maintain range of motion. The findings were: 1. Review of the 2/12/19 annual MDS assessment showed resident #10 had a brief interview for mental status (BIMS) score of 13	F 688	The facility will consistently provide restorative nursing care for all residents who require this care to maintain range of motion. A)OT will review restorative programs for residents #10, #27, #37, and #40 and revise and update as necessary. Resident #28 was admitted to the hospital	7/4/19

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F 688	Continued From page 4 (cognitively intact), limited mobility, and inability to balance and transfer without assistance. Review of the 4/12/19 and 5/14/19 occupational therapy evaluation notes showed the resident had positioning, balance, and lower extremity functional deficits. Review of the May 2019 nursing orders and problem activity records showed restorative interventions included lower extremity adduction, passive range of motion for ankle dorsiflexion, and passive range of motion for hamstring strength 3 to 5 times weekly. This review also showed group exercises and active range of motion were to be provided 1 to 3 times weekly. Review of the 4/1/19 to 5/14/19 (a total of 6 weeks) problem activity records showed some or all of the restorative interventions were performed on only 6 days (4/8/19, 4/19/19, 4/30/19, 5/6/19, 5/7/19, and 5/13/19). Further review showed on 6 days during the same time period staff documented the resident did not want restorative interventions due to pain, or declined without giving a reason. 2. Review of the 3/18/19 significant change MDS assessment showed resident #27 had a BIMS score of 5 (severely impaired), limited range of motion in the upper and lower extremities, and an inability to balance and transfer without assistance. Further review showed the resident required extensive assistance of 1 person for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Review of the May 2019 nursing orders and problem activity records showed restorative interventions included supine knee flexion/extension 5 to 10 repetitions 1 to 3 times weekly, seated marching 10 repetitions 1 to 3 times weekly, seated knee flexion 10 repetitions, 1 to 3 times weekly, shoulder flexion/extension 10 repetitions 1 to 3 times	F 688	on 5/28/19 and will be re-evaluated for restorative program upon return to AHCC. B)An audit of all resident records who currently receive restorative nursing care will be completed by restorative CNA and OT or designee to identify any other residents who may not be receiving consistent restorative care. If other residents are identified, their restorative programs will be evaluated for appropriateness and corrective action taken. OT,PT and restorative CNA will develop a formalized restorative program policy and procedure. This program will include restorative plans with interventions based on individualized assessed needs, goals, and a process for reviewing refusals to determine the best approach. C)OT or designee will educate restorative staff on the formalized restorative program and the importance of documentation and communication with PT, OT and nursing to ensure each individual resident receives the most appropriate interventions and restorative program. D)A performance improvement tool will be developed to monitor compliance with documentation of, performance of and the effectiveness of restorative exercises and interventions including those for refusals. This will include at least 6 observations and chart audits per month, will be completed monthly by restorative CNA and reviewed quarterly by QAPI	

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F 688	Continued From page 5	F 688		

weekly, group exercise 1 to 2 times weekly, neck passive range of motion 1 to 3 repetitions for 30 seconds 1 to 3 times weekly, bilateral heel cord stretch 5 times 1 minute or 1 to 5 minute stretch, and bilateral elbow flexion/extension 10 repetitions 1 to 3 times weekly. Review of the 4/1/19 to 5/14/19 (a total of 6 weeks) problem activity records showed no restorative activities or refusal of restorative was documented between 4/23/19 and 5/8/19 (16 days).

3. Review of the 3/18/19 significant change MDS assessment showed resident #28 had a BIMS score of 15 (cognitively intact), limited range of motion due to a stroke, and inability to balance and transfer without assistance. Review of the 3/15/19 occupational therapy evaluation notes showed the resident had decreased active and passive range of motion and the functional mobility goals were to participate with restorative exercises and walking 3 to 5 times weekly. Review of the 3/15/19 to 5/14/19 (a total of 8 weeks) problem activity records showed some or all of the restorative interventions were performed on only 11 days. Further review showed on 7 days during the same time period, staff documented the resident did not want restorative interventions due to pain or declined without giving a reason. Interview with the resident on 5/14/19 at 8:40 AM revealed s/he did not receive much benefit from the restorative program because it was primarily exercising during activities. The resident further stated it was not the same as having range of motion for specific areas of the body.

4. Review of the 4/14/19 quarterly MDS assessment showed resident #37 had a BIMS score of 15 (cognitively intact), and diagnoses

committee.

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F 688	Continued From page 6	F 688		

that included Parkinson's Disease. Review of the 1/4/19 occupational therapy evaluation notes showed the resident had mobility and balance deficits and was at risk for developing contractures. This review also showed the functional mobility goals were to participate with a restorative program and walk with the restorative CNAs 3 to 5 times weekly. Review of the 4/1/19 to 5/14/19 (a total of 6 weeks) problem activity records showed some or all of the restorative interventions were performed on only 13 days. Further review showed on 6 days during the same time period, staff documented the resident did not want restorative interventions due to pain or declined without giving a reason.

5. Review of the 4/21/19 quarterly MDS assessment showed resident #40 had a BIMS score of 15 (cognitively intact), required assistance with ambulation and had unsteady balance. Review of the current list of restorative interventions for the resident showed 11 different restorative interventions were to be performed 3 to 5 times weekly. Further review showed the 12th intervention was ambulation and it was to be performed 5 to 7 times weekly. Review of the 4/1/19 to 5/14/19 problem activity records showed the 11 interventions were not performed 3 to 5 times weekly; nor was ambulation performed 5 to 7 times weekly. Interview with the resident on 5/13/19 at 4:48 PM revealed s/he did exercises 3 times a week as an activity with other residents.

6. On 5/16/19 at 11:15 AM interview with restorative aide #1, activity director, and occupational therapist #1 revealed the restorative program was not formalized, and they did not have a system for evaluating and reassessing interventions or effectiveness. At that time the

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F 688	Continued From page 7 occupational therapist verified the restorative program did not include restorative plans with interventions based on individualized assessed needs, goals, and a process for reviewing refusals related to pain or other reasons to determine the best approach.	F 688		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure bed rails were assessed for safety for 3 of 3 sample residents (#5, #27, #92) with bed rails. The findings were:	F 700	The facility will ensure that bed rails are assessed for safety for all residents. A)DON competed a bed rail safety assessment for residents #5, #27, and	7/4/19

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F 700	Continued From page 8 1. Observation on 5/13/19 at 3:19 PM showed resident #5 had bed rails attached to the upper portion of his/her bed. Review of a "side rail" safety assessment showed it was completed on 5/15/19. 2. Observation on 5/13/19 at 3:08 PM showed resident #27 had an air mattress and bed rails attached to the upper portion of the bed on each side. The right side of the bed was against the wall. Review of the medical record showed the last "side rail" safety assessment was completed on 1/10/17. 3. Observation on 5/13/19 at 3:10 PM showed resident #92 had a raised perimeter air mattress and bed rails attached to the upper portion of the bed. Review of a "side rail" safety assessment showed it was completed on 5/15/19. 4. Interview with the DON on 5/15/19 at 5:36 PM revealed there were no previous side rail assessments for resident #5 or #92 and the facility did not have a timeline for re-evaluation of side rails. Further she revealed the facility wanted to update the form and then complete all side rail assessments.	F 700	#92 on 5/15/19. B)DON also completed a bed rail safety assessment for all other residents on 5/15/19. C)DON will write a policy that a bed rail safety assessments will be completed (by DON) with every new admission and every full MDS, whether yearly or for change of condition. The most recent assessment will replace the previous one and be visible and accessible in each resident's record in the CPSI computer system. D)DON will develop a performance improvement tool to ensure all newly admitted residents and residents with a change of condition or yearly MDS have a new bed rail safety assessment completed. The DON will complete this tool monthly and it will be reviewed quarterly by the QAPI committee.	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		7/4/19

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F 759	Continued From page 9 Based on observation, medical record review, and staff interview, the facility failed to ensure medications were administered per manufacturer instructions for 3 of 25 medication administration observations, resulting in an error rate of 12%. The findings were: 1. Review of the May 2019 physician orders recapitulation for resident #31 showed orders initiated on 8/23/18 for symbicort inhalant twice daily. Observation on 5/13/19 at 5:40 PM, showed MA-C #1 administered the inhaler to the resident in the dining room. Continuous observation showed the resident stopped eating, used the inhaler and returned to eating without performing an oral rinse after using the inhaler. 2. Review of the May 2019 physician orders recapitulation for resident #28 showed orders for fluticasone inhalant daily. Observation on 5/13/19 at 5:45 PM, showed MA-C #1 administered the inhaler to the resident and did not provide an oral rinse after administration. 3. Observation on 5/15/19 at 8:15 AM showed MA-C #1 administered symbicort inhalant to resident #31 during breakfast in the dining room. Further observation showed the resident stopped eating, used the inhaler and returned to eating without performing an oral rinse after using the inhaler. 4. Interview on 5/15/19 at 8:48 AM with the medication aide revealed she usually asked the residents to rinse after inhalers, and was not sure why she had not done it during the surveyor observations. 5. Interview on 5/15/19 at 11:10 AM, with the	F 759	The facility will ensure medications are administered per manufacturer instructions. A)DON reviewed F759 deficiency with MA-C #1. Pharmacy placed a sticker on resident #31's symbicort inhaler label and resident #28's fluticasone inhaler label directing to "Rinse Mouth After Use." DON or designee will observe resident #31 receiving symbicort inhaler and resident #28 receiving fluticasone inhaler and provide immediate inservicing if nurses or MA-C do not have these residents rinse their mouths by taking fluids after using these inhalers. B)An audit of all resident inhalant medication will be completed by DON or designee to identify other residents with inhalers that require an oral rinse after administration of medication. Pharmacy will place reminder stickers on these medications to remind medication nurses and MA-C of the need to rinse resident's mouth after use. DON or designee will monitor the administration of inhalers at least six times per month. C)DON or designee will educate all nurses and MA-Cs on the need to provide residents with an oral rinse after the use of inhalers that present a risk of oral yeast infections. D)DON or designee will develop a performance improvement tool to monitor administration of inhalers with risk of oral yeast infection and ensure they are being	

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F 759	Continued From page 10 pharmacist revealed the expectation was for staff to follow the United States Food and Drug Administration (FDA) recommendations that required residents to rinse with water after using symbicort and fluticasone inhalers.	F 759	administered appropriately and an oral rinse is being provided after administration. This will be completed monthly and include at least 6 observations per month. It will be reviewed quarterly by the QAPI committee.	
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, staff interview, review of the facility's infection prevention records, and policy and procedure 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 43. The findings were: 1. Review of the facility's infection prevention records for April 2019 showed resident #14 was ordered 3 antibiotics for treatment of a urinary tract infection between 4/9/19 and 4/18/19. The following concerns were identified: a. Review of a "Patient Progress Notes" entry dated 4/9/19 and timed 8:12 AM showed the resident had urinalysis ordered following an ER visit. Review of a "Patient Progress Notes" entry	F 881	The facility will establish an infection prevention and control program with antibiotic use protocols and a system to monitor antibiotic use. A)Resident #14 is deceased, therefore no corrective action for resident is possible. B)Infection Preveionist will complete a review of all resident charts to ensure those residents receiving antibiotic are receiving the appropriate antibiotic for their specific infection. The Infection Preventionist and Pharmacist will update the Antibiotic Stewardship Policy to be more specific to Amie Holt Care Center, using the "CDC Core Elements of	7/4/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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dated 4/9/19 and timed 6:08 PM showed a physician ordered "Bactrim DS [antibiotic] BID [twice per day]..." Review of the urinalysis results dated 4/9/19 showed a culture and sensitivity was not performed.

b. Review of an "Emergency Room Note" dated 4/18/19 an timed 7:54 AM showed the resident was seen on 4/17/19 and the "History of Present Illness" showed "The patient has declined over the last several days. [S/he] was seen last week and evaluated for a possible urinary tract infection and treated for this with Bactrim twice daily. [S/he] finished the Bactrim yesterday, but over the last few days, [s/he] has had a decreased appetite, worsened interaction, confusion, and weakness..." Further review showed the "Plan" for treatment was "The patient is placed on doxycycline [tetracycline antibiotic] 100 mg [milligrams] twice daily for the next 7 days. Urine is cultured to assure we have [him/her] on appropriate antibiotics."

c. Review of the urinalysis results dated 4/17/19 showed the resident was positive for leukocyte esterase which was resistant to tetracycline antibiotics.

d. Review of a "Patient Progress Note" entry dated 4/18/19 and timed 6:15 PM showed "New order for amoxicillin [antibiotic] 500 mg BID [twice per day] x [times] 10 doses. The culture had come back and [s/he] was on the wrong ABO [antibiotic]..."

e. Interview with the infection preventionist on 5/16/19 at 12:28 PM confirmed the resident was on multiple antibiotics and revealed the medications were unnecessary and there was no evidence of antibiotic review or physician communication related to the appropriateness of the antibiotic use. Further interview revealed the antibiotic stewardship program was a "work in

Antibiotic Stewardship for Nursing Homes" for guidance.

C)Infection Preventionist and Pharmacist will provide education on basic principles of antibiotic stewardship and on the updates to the Antibiotic Stewardship Policy specific to AHCC to AHCC nurses and Medical Staff.

D)Infection Preventionist or designee will develop a performance improvement too to ensure antibiotics are being used appropriately and changes in policy are being followed. They will complete this PI tool monthly and the QAPI committee will review quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	C 05/20/2019

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progress" and the facility had "opportunities to improve."

f. Review of the policy titled "Antibiotic Stewardship" dated 1/27/18 showed "...It is the policy of Johnson County Healthcare Center to implement an Antibiotic Stewardship Program (ASP) which will promote the appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use...a. JCHC will provide protocols to address...iii. An antibiotic review process, also known as "antibiotic time-out" (ATO) for all antibiotics prescribed in the facility. ATOs prompt clinicians to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information available..."