STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	10/24/2019

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WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 10/21/19 to 10/24/19. The following common abbreviations are used throughout this document. CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		11/15/19

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

Electronically Signed | 11/15/2019

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F 623	Continued From page 1	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a discharge notice was issued to 2 of 5 sample residents (#11, #36) reviewed for transfer	F 623	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Wind River Rehabilitation and Wellness Center	

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F 623	Continued From page 3 and discharge. Further the facility failed to ensure the ombudsman was notified and appropriate protection and advocacy information was provided for 3 of 5 sample residents (#11, #36, #271) who discharged or transferred from the facility. The findings were: 1. Review of the medical record for resident #11 showed the resident was hospitalized on 10/11/19 following a physician's visit. The transfer notice indicated the the resident's representative provided "verbal" acknowledgement; however, there was no evidence of a signed transfer notice in the resident's record and there was no evidence the notice was sent to the State LTC Ombudsman. 2. Review of the medical record for resident #36 showed the resident was hospitalized on 7/7/19. There was no evidence of a signed transfer notice in the resident's record and there was no evidence the notice was sent to the State LTC Ombudsman. 3. Review of medical record for resident #271 showed the resident discharged the facility against medical advice (AMA) on 9/2/19. The resident had signed the notice of AMA discharge on 9/3/19; however, there was no evidence the notice was sent to the State LTC Ombudsman. 4. Interview with social services director on 10/23/19 at 2:25 PM revealed he was unaware of the requirements to send a copy of the discharge or transfer notice to the ombudsman for hospitalizations and AMA discharges. As a result, notices were not sent to the ombudsman for residents #11, #36, and #271.	F 623	does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Corrective Actions: RCM obtained a transfer and discharge notice for residents #11, and 36. SSD sent via email, the ombudsman the appropriate protection and advocacy information for residents #11, #36, #271. Identification of Others: Transfer and Discharge notices along with Ombudsman Notification was Audited for the past two months of-September and October 2019. Any deficiencies were immediately corrected. Systemic Changes Licensed Nurses and IDT members have been educated on the Transfer and Discharge expectations by DNS on 10/28/19 and 11/04/19. SSD was trained on 10/28/2019 on the expectations of the Notice to Ombudsman along with advocacy information. Monitoring for Compliance Recent Transfers/Discharge Residents out of the facility will be reviewed in the am clinical meeting M-F by SSD and RCM to ensure the transfer/discharge documentation is complete and in the chart. Recent Residents that have transferred/discharged will be reviewed by	

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F 623	Continued From page 4 5. Interview with the DON on 10/24/19 9:20 AM revealed the transfer notification for resident #36 could not be located. Further interview confirmed the company policy was the transfer notice must be signed and filed in the resident's chart. 6. Review of facility discharge/transfer notice showed the contact information for the advocacy agency for individuals with intellectual and developmental disabilities and individuals with mental illness was incorrect. 7. Review of the policy titled "Transfer and Discharge" updated March 2017 showed "...5. When the transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge which includes the includes [sic] the following items: a. Date notice is given. b. Effective date of the transfer/discharge. c. Reason for the transfer/discharge. d. Where the resident is to be mover. e. Contact information for the State Long-Term Care Ombudsman. f. Contact information for protection and advocacy agency for residents with a mental disorder, intellectual disability, developmental disability, or other related disability. g. Explanations of right to appeal the transfer or discharge. h. Additional information required by applicable. 6. The Center sends a copy of the notice to the State Long-Term Care Ombudsman..."	F 623	SSD and DNS to ensure Ombudsman and appropriate protection and advocacy has been notified. Audits of Transfer/Discharge Notices will be conducted by the RCM or designee X 4 weeks then Monthly X 2 Months, and results will be brought to the monthly QAPI. Audits of Notice to the ombudsman and appropriate protection advocacy will be conducted by the SSD or designee X 4 weeks then Monthly X 2 Months, and results will be brought to the monthly QAPI. An AdHoc QAPI meeting was held on October 29th, 2019 to discuss this POC and its adaptation.	
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	F 641		11/15/19

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F 641	Continued From page 5 by: Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 2 of 21 sample residents (#1, #60). The findings were: 1. Review of the medical record for resident #1 showed the resident was admitted to the facility on 5/24/19 for rehabilitation following a hip fracture and was discharged to the community on 6/7/19. Further review of the medical record showed a MDS entry tracking record was submitted on 5/24/19 and a MDS discharge-return not anticipated assessment was completed on 6/7/19. The resident was coded as "female" on each of these assessments. An admission MDS assessment was completed on 5/31/19 and the resident was coded as being "male". The inaccurate gender coding resulted in the admission MDS assessment not having a corresponding discharge assessment. 2. Review of the most current physician orders showed resident #60 had been prescribed Eliquis (an anticoagulant), 5 mg twice daily with a start date of 3/20/19. Review of the anticoagulation care plan, last revised 3/28/19 showed the resident was on anticoagulation therapy related to a history of CVA (cardiovascular accident). Review of the September 2019 MAR (medication administration record) showed the resident received the scheduled medication, as ordered, every day of the 7-day look-back period. However, review of the quarterly MDS assessment dated 9/28/19 revealed the anticoagulant was not included in the medication section of the MDS.	F 641	Corrective Actions: Resident #1 was identified to have inaccurate MDS assessment; it was revised by MDS Coordinator. Resident #60 was identified to have an inaccurate MDS assessment it was revised by MDS coordinator. Identification of Others MDS assessments have been reviewed by MDS Coordinator for gender coding and accuracy. MDS have been reviewed on 11/04/19 by MDS Coordinator for all of the residents on an anticoagulant, to ensure the anticoagulant is listed in the medication section of the MDS. Systemic Changes MDS Coordinator and Back up MDS have been educated on the expectations ensuring MDS assessments are accurate, this was conducted on 11/8/19. Monitoring for Compliance New Admits will be reviewed in clinical meeting, at 72-hour meeting to ensure the MDS is accurate with gender, and if on anticoagulants coded as such. LTC residents will be reviewed quarterly during their assessment and at any change of condition. Audits of MDS will be conducted by the MDS nurse or designee weekly X 4 weeks then Monthly X 2 Months, and results will be brought to the monthly QAPI. An AdHoc QAPI meeting was held on October 28, 2019 to discuss this POC and its adaptation.	

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F 641	Continued From page 6 3. Interview with MDS coordinator on 10/23/19 at 3:39 PM revealed she was unaware anticoagulants, such as Eliquis, needed to be coded in section N of the MDS. In addition she confirmed the gender of resident #1 was marked in error and the MDS should be modified. 4. According to the MDS 3.0 RAI Manual version 1.15, page 478: Section N0410E, Anticoagulant: "...Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period..."	F 641		
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 observation, resident representative and staff interview, medical record review, activity calendar review, and policy and procedure review, the facility failed to ensure residents were offered meaningful and ongoing activities designed to improve or maintain the physical, mental, and psycho-social well-being for 2 of 6 sample residents (#20, #56) reviewed for activities. The findings were:	F 679	Corrective Actions: Immediate review of Activities (in the secure unit), Care Plans and documentation. Changes to Activity Care Plans were made to include dates, time and specific interests Identification of Others All Residents in the secured unit's Care Plans and were reviewed and changed to	11/15/19

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F 679	Continued From page 7 1. Observation on 10/22/19 between 8:15 AM through 11:30 AM showed there were no activities performed in the secure unit. Music was playing on the radio and a program with changing environmental scenes was playing on the television. No residents in the area appeared to be watching the program. 2. Review of the significant change MDS assessment dated 10/4/19 showed resident #20 showed was unable to complete the activities interview section. The staff assessment showed the resident's preferences included listening to music, spending time outdoors, and participating in religious activities or practices. Review of the care plan last revised on 9/30/19 showed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs due to cognitive deficits. Interventions included "...Ensure the activities [resident's name] is attending are: Compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate..." The following concerns were identified: a. Observation on 10/21/19 at 4:36 PM showed staff and residents of the secure unit were engaged in a coloring activity and resident #20 was sleeping in a recliner. b. Observation on 10/23/19 at 9:30 AM showed a kick ball activity was in progress and the resident was positioned at a dining table attempting to watch the activity. Continued observation showed the resident was assisted into the kick ball circle at 9:55 AM at which time	F 679	meet specific activities. Systemic Changes Nursing staff was educated on meaningful activities and ongoing activities designed to improve or maintain the physical, mental and psychosocial well-being of the Residents, along with documentation of Activities on 11/08/2019, and Secure Unit on 11/12/19. Monitoring for Compliance Audits will be conducted including observations, documentations and review of Care Plans by the Activity Director weekly X 6 weeks. Results of the audits will be brought to the Monthly QAPI meeting for review, recommendations and need for ongoing monitoring. As AdHoc QAPI meeting was held on October 29, 2019 to discuss this POC and it adaptation.	

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	535031	A. BUILDING _____ B. WING _____	10/24/2019

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F 679	Continued From page 8	F 679		

the activity concluded. Review of the "Activity Participation Record" from 9/1/19 through 10/22/19 showed the resident was documented as "active" participation 7 times for "Walking/Wheeling Outdoors/Indoors," and 2 times for "Exercise/Sports." Further review showed the resident was documented as "Wandered In/Out" 5 times; however, review of the 10/4/19 significant change MDS assessment showed the resident required extensive physical assistance of 1 person for bed mobility, transfers, walk in room and corridor, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing.

c. Observation on 10/23/19 at 2:14 PM showed staff performing nail care to residents in the secure unit. The resident was seated at a dining table, away from the activity and was not engaged in the activity. Further observation showed a movie with changing environmental scenes was playing on the television.

d. Review of the "Activity Participation Record" from 9/1/19 to 10/22/19 showed the resident was documented as "active" for participation 27 times for "Talking/Conversing;" however, review of the 10/4/19 significant change MDS assessment showed the resident had diagnoses which included Alzheimer's disease, aphasia, and non-Alzheimer's dementia, had no speech, was rarely or never understood, and rarely or never understands.

e. Further review of the care plan last revised on 9/30/19 showed there was no evidence of interventions related to the resident's activity likes and dislikes, time of day the resident was likely to participate, resident specific one-to-one activities, or appropriate level of staff assistance and encouragement.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 679	Continued From page 9	F 679		

3. Review of the annual MDS assessment dated 6/27/19 showed resident #56 was unable to complete the activities interview section. The staff assessment showed the resident's preferences included listening to music, spending times outdoors, and participating in religious activities or practices. Review of the care plan last revised on 9/30/19 showed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs due to cognitive deficits. Interventions included "...Ensure the activities [resident's name] is attending are: Compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate..." The following concerns were identified:

a. Observation on 10/21/19 at 4:36 PM showed staff and residents of the secure unit were engaged in a coloring activity and the resident did not participate.

b. Interview with the resident's representative on 10/22/19 at 8:46 AM revealed the resident was not able to participate in activities the facility provided due to his/her diagnosis.

c. Observation on 10/23/19 at 9:31 AM showed a kick ball activity was in progress and the resident did not participate in the activity. The resident was observed ambulating around unit and walked through the center of the activity. Staff members assisted the resident into a recliner near the activity; however, s/he was not offered or positioned in a way to participate in the activity.

d. Observation on 10/23/19 at 2:14 PM showed staff were performing nail care for residents and the resident ambulated around the

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WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

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F 679	Continued From page 10	F 679		

unit and did not engage in the activity. Further observation showed a movie with changing environmental scenes was playing on the television.

e. Review of the "Activity Participation Record" from 9/1/19 to 10/22/19 showed the resident was documented as "active" for participation 38 times for "Talking/Conversing;" however, review of the 9/27/19 quarterly MDS assessment showed the resident had diagnoses which included non-Alzheimer's dementia, and was rarely or never understood, and rarely or never understands.

f. Further review of the care plan last revised on 9/30/19 showed there was no evidence of interventions related to the resident's activity likes and dislikes, time of day the resident was likely to participate, resident specific one-to-one activities, or appropriate level of staff assistance and encouragement.

4. Review of the activity calendar for October 2019 showed there were no scheduled times for activities to be performed.

5. Interview with the activity director on 10/23/19 at 1:36 PM revealed she was unsure why resident #20 and #56 were marked as active participation in activities if they were not participating in activities. She revealed if the residents were in the same room the activity was going on staff should chart the actual level of participation. Further interview revealed the CNAs in the secure unit were responsible for conducting the activities and there were no set times so they could conduct the activities when they had time.

6. Interview with the activity director on 10/23/19 at 4:18 PM revealed staff may not understand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	10/24/2019

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F 679	Continued From page 11 appropriate documentation of activity involvement. Further, she confirmed that there may be some items that were documented as activities by staff that did not engage residents. 7. Review of the policy title "Activity Program" updated July 2015 showed "...1. The activity program: a. Is multifaceted to reflect the entire resident population's needs and interests...2. The Activity Director is responsible for overall supervision, direction, and management of the activity program including: a. Reviewing activities and attendance monthly..."	F 679		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		11/15/19

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	535031	A. BUILDING _____ B. WING _____	10/24/2019

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WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

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F 758	Continued From page 12 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure appropriate psychotropic medication use for 2 of 5 sample residents (#19, #57) identified for a medication regimen review. The findings were: 1. Review of the "Medication Review Report" for October 2019 showed resident #19 received citalopram hydrobromide (anti-depressant) 20 milligrams (mg) 1 tablet by mouth in the morning for major depressive disorder and quetiapine fumarate (anti-psychotic) 25 mg 1 tablet by mouth	F 758	Corrective Actions: Resident #19 Behavioral Monitoring Flowsheet was updated on 10/24/19 by MDS coordinator with both Target Behaviors and interventions for each of the medications Resident #19 is taking. Resident #57 Behavioral Monitoring Flowsheet was updated on 10/24/19 by MDS coordinator with both Target Behaviors and interventions for each of the medications Resident #57 is taking. Identification of Others Audit of all Behavioral Monitoring	

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F 758	Continued From page 13 every day and evening shift related to dementia with behavior disturbances. The following concerns were identified: a. Review of the "Behavior Monthly Flowsheet" For September 2019 and October 2019 showed there was no specific target behaviors identified for the use of each medication. 2. Review of the "Medication Review Report" for October 2019 showed resident #57 received Abilify (anti-psychotic) 15 mg 1 tablet by mouth in the morning related to dementia with behavior disturbance, generalized anxiety disorder, and major depressive disorder recurrent severe without psychotic features; duloxetine hydrochloride (anti-depressant) capsule delayed release particles 60 mg 1 capsule by mouth in the morning related to major depressive disorder recurrent severe without psychotic features; and trazodone hydrochloride (anti-depressant) 100 mg 1 tablet by mouth at bedtime related to dementia with behavioral disturbance, generalized anxiety disorder, and major depressive disorder recurrent severe without psychotic features. The following concerns were identified: a. Review of the "Behavior Monthly Flowsheet" For September 2019 and October 2019 showed there was no specific target behaviors identified for the use of each medication. 3. Interview with the DON on 10/23/19 at 11:25 AM confirmed the facility did not document specific target behaviors for individualized medications. Further interview revealed the facility documented all behaviors and then attempted to determine which medication to	F 758	Flowsheets on 10/24/19 by MDS and RCM; of residents who are administered Psychotropic Medications to ensure Both Target Behaviors and Interventions for each medication any discrepancies found were corrected immediately. Systemic Changes Licensed nurses were re-educated by SDC on the Psychotropic Policy and Procedure to ensure understanding, on 10/28/2019. Residents with Psychotropic Medications will be reviewed weekly at the Psychotropic Monitoring meeting and once per month with the Pharmacist to ensure that the behavioral monitoring sheets have target behaviors and interventions that are in-line with the Psychotropic medications they are administered. Monitoring for Compliance Audit of Behavioral Monitoring sheets will be completed by SSD or designee: Weekly X 4 weeks then Monthly X 2 months to ensure the policy and procedure is followed including Interventions. Results will be reviewed at monthly QAPI for review, recommendations and need for ongoing monitoring. An AdHoc meeting was held on October 28th, 2019 to discuss this POC and its adaptation.	

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F 758	Continued From page 14 complete a reduction based on overall behavior documentation. 4. Review of the policy titled "Psychotropic Drugs" updated January 2019 showed "2. Psychotropic drugs can be therapeutic and enhancing quality of life for residents suffering from mental illnesses (schizophrenia, depression, etc.), the Interdisciplinary Team (IDT) validates there are appropriate diagnosis of behavioral symptoms, so the underlying cause of the symptoms is recognized, and the condition is treated appropriately...5. Prior to initiating any psychotropic drug, the IDT:...d. The Interdisciplinary Team (IDT) evaluates the resident's medication regime to validate the resident is not receiving duplicate drug therapy. Duplicate drug therapy is any drug therapy that duplicates a particular drug effect on the resident, wether from the same drug category or not...6...iv. initiate medication at lowest possible dose and only gradually increase the dose with documentation of continued behavior symptom to justify the increase..."	F 758		
F 881 SS=D	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:	F 881		11/15/19

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F 881	Continued From page 15 Based on medical record review, and staff interview, the facility failed to ensure antibiotics were appropriate for 1 of 5 sample residents (#58) who received antibiotic therapy. The findings were: 1. Review of a wound culture report dated 8/28/19 showed resident #58 had a wound culture of a diabetic ulcer on the left foot. Review of the culture and sensitivity dated 9/1/19 showed the lab identified the organism MRSA (Methicillin Resistant Staphylococcus Aureus) in the wound and the organism was indicated to be resistant to the antibiotic Ciprofloxin. The following concerns were identified: a. Review of the MAR (Medication Administration Report) for October 2019 showed the resident had an order dated 10/15/19 for Ciprofloxin 500 milligrams (mg) by mouth, twice a day for 14 days and the medication was started on the morning of 10/16/19. b. Review of nursing progress note dated 10/18/19 and timed 9:05 PM showed " ... Area of diabetic ulcer is measuring 2 cm in diameter and includes yellowish, callous-like tissue that is more prominent to the proximal portion of ulcer. Center of ulcer area is an open area that measures 0.75 cm x 0.5 cm and still has a dark reddish/brown wound bed. Wound bed is 0.3 cm deep. No drainage or swelling to foot. Some odor is noted to area. Area remains tender to the touch. Dressing change completed. Resident continues their po [by mouth] Cipro [Ciproflofloxin] 500 mg BID [twice daily] x 14 days No adverse symptoms per abx [antibiotic] therapy noted." c. Review of a notification from the resident's primary care provider on 10/22/19 at 2:25 PM showed "Please let nursing home know that the culture shows prevotella and MRSA. We need to	F 881	Corrective Actions: Resident #58 Antibiotic Ciprofloxin was discontinued, a susceptible antibiotic Bactrim DS was continued. Identification of Others Residents on antibiotics were reviewed for correct antibiotics in correlation with lab results, by IP on 11/08/19. Systemic Changes Licensed Nurses were educated on 11/08/2019 on Antibiotic use, including reading the labs/cultures. SDC/IP nurse was educated on the expectation of monitoring the floor nurses and the lab/cultures associated with Antibiotics. Monitoring for Compliance Weekly audits will be conducted by IP, X 4weeks, then 1X per month X2 months, on all residents on antibiotic medications to ensure the medications and labs are appropriate. An Adhoc QAPI meeting was held on October 28th, 2019 to discuss the POC and its adaption.	

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F 881	Continued From page 16 add 14 days of Bactrim DS BID." 2. Interview with DON and the infection control nurse on 10/24/19 at 9:20 AM confirmed the resident continued to receive Ciprofloxin twice daily and the order for Bactrim DS administration began on 10/23/19. They revealed the Ciprofloxin should have been discontinued as it was not appropriate; however, they were unsure why the original culture report was not reviewed.	F 881		