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	53A051	A. BUILDING _____ B. WING _____	11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 11/4/19 to 11/7/19. The following common abbreviations are used throughout this document: CAT- Care Area Triggers CNO- Chief Nursing Officer DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life	F 565		12/13/19

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

Electronically Signed | 12/02/2019

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F 565	Continued From page 1 in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, review of resident council meeting minutes, review of resident council problem resolution forms, and review of facility policy, the facility failed to provide evidence of any resolution or notification regarding group grievances for 3 of 3 months reviewed (August 2019, September 2019, October 2019). The findings were: 1. Group interview with 7 residents on 11/5/19 at 2 PM revealed ongoing concerns with poor food quality and laundry items being damaged or lost. The residents identified the activities director as the grievance official who documented complaints brought up in the resident council meetings. a. Review of the resident council minutes dated 8/2/19 showed concerns with inconsistent call light responsiveness and all residents at a table being served at the same time during meals. The "Resident Council Minutes - Problem Resolution Form" showed resolutions of "coaching in staff mtg..." for both concerns and	F 565	1. We will check with each resident for unresolved grievances and document the grievance along with the resolution by 12/13/2019. 2. In order to correct all of the current unresolved resident grievances, a resident council will be held on December 3rd for the DON to report updates on grievances reported on 11/5/19 regarding poor food quality and laundry issues, on 8/2/2019 for call light responsiveness, on 9/6/2019 for housekeeping, request for fresh fruit and TV programs, and 10/11/2019 for missing clothing and laundry issues. 3. Moving forward the Activities Coordinator will continue to fill out her meeting minutes as before but will also fill out a grievance/complaint report and give to the DON within 24 hours of resident counsel meetings. This will start immediately and be ongoing.	

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F 565	Continued From page 2 both were signed as complete on 8/21/19. The resolution did not show any additional information about how the concern was resolved or how the residents were notified of the resolution. b. Review of the resident council minutes dated 9/6/19 showed concerns with housekeeping, availability of fresh fruit, and availability of television programs. The "Resident Council Minutes - Problem Resolution Form" showed resolutions which included notifying the housekeeping manager, adding fresh fruit to the menu, and working with activities and maintenance departments to find a solution; those concerns were signed as complete on 9/18/19, 9/16/19, and 9/20/19, respectively. The resolutions did not show any other information about how the concerns were resolved or how the residents were notified of resolution. c. Review of resident council minutes dated 10/11/19 showed concerns with missing clothing and laundry items going to the wrong residents. The "Resident Council Minutes - Problem Resolution Form" showed resolutions of an email sent to laundry supervisor and monthly closet checks; this was signed as complete on 11/4/19. The resolution did not show any other information about how the concerns were resolved or how the residents were notified of the resolution. d. Interview with the activities director on 11/6/19 at 1:40 PM revealed her responsibility in the process for concerns presented in resident council. She stated she verbally shared the concerns with the DON and documented those concerns on the meeting minutes. The DON provided verbal updates on the concern however, there was no clear process on communicating with the residents on the details of the complaints or how they were addressed. e. Interview with the DON on 11/6/19 at 3:19	F 565	4. The DON and activities coordinator were educated on how to fill out the new grievance form and the follow up form on 12/2/2019. 5.. The DON will then document her follow up as well as the resolution within 48 hours of receiving the grievance from the Activities Coordinator. This will start immediately and be ongoing. 6. The activities coordinator will follow up with the resident who made the grievance report in within 1 week and ask the follow up tool questions. This will begin immediately and be ongoing. 7. The DON will be scheduled 10 minutes at the beginning of every resident counsel to update the residents as a group regarding the concerns brought up in resident council. This will begin immediately and be ongoing 8. All complaints will be documented on a grievance report and tracked on the LTC QA tracking sheet along with the follow up tool questions and the presence of the DON at the beginning of every resident council. This will begin immediately and be ongoing. 9. The DON or designee will track all grievances, follow up tools and attendance of the DON at resident council on an ongoing monthly basis starting in December and will be reported to the QAPI committee monthly starting in December 2019.	

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F 565	Continued From page 3 PM revealed she was the person responsible for resolving grievances and concerns identified in the resident council. She stated she would communicate with the relevant department heads regarding resident concerns, but there was no system in place to ensure the grievances were resolved or the results were reported to the residents. f. Review of the facility grievance policy showed it identified the DON as the grievance official, who "...will have 24 hours from the time a complaint is reported to make contact with the resident regarding the complaint...and the goal is to be done within no more than 5 business days pending (sic) on the type of grievance."	F 565		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		12/13/19

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F 636	Continued From page 4 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

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F 636	Continued From page 5 Based on medical record review, staff interview, and review of the Resident Assessment Instrument User's Manual, the facility failed to ensure a comprehensive assessment was completed for needed areas for 2 of 2 residents (#1, #9) who were reviewed for assessments. The findings were: 1. Review of the initial MDS assessment, with an assessment reference date (ARD) of 8/12/19, for resident #1 showed the following care areas were triggered: communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, pressure ulcer, and psychotropic drug use. Review of the "CAT [care area triggers] Worksheet" for each of the triggered areas showed there was not a comprehensive assessment. Although there were checkmarks for some indicators, there lacked an analysis of findings to describe the problem, and identify possible causes and contributing factors and risk factors. The "Analysis of Findings" section was blank for all the worksheets. 2. Review of the significant change MDS assessment, with an ARD of 10/30/19, for resident #9 showed the following care areas were triggered: delirium, cognitive loss, visual function, communication, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, activities, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and psychotropic drug use. Review of the "CAT Worksheet" for each of the triggered areas showed it was not a comprehensive assessment. Although there were checkmarks for some indicators, there lacked an analysis of findings to describe the problem, and identify possible	F 636	1. An addendum will be made to residents #1 and #9 CAT worksheet to show accuracy and completioin. This will be done by 12/13/2019. 2. In order to assure that all residents CAT worksheets are accurate, the MDS coordinator will review all CAT worksheets for accuracy and completion of the most recent CAT worksheet by 12/13/2019. 3. The DON will provide education to the MDS coordinator regarding the state findings the week of 12/1/2019 and how to correctly fill out the CAT worksheet when doing a comprehensive assessment on all residents moving forward. 4. The DON or designee will continue to track all significant changes, comprehensive assessments and the CAT that are done on a monthly basis. Prior to submitting to the state the DON will review the CAT worksheet with the MDS coordinator to ensure that an accurate comprehensive assessment was done. This will be done on a weekly basis x 1 month starting the week of 12/8/2019 then biweekly x 1 month then monthly. 5. All tracking will be logged on the LTC QA tracking sheet and reported to the QAPI committee on a monthly basis starting in December 2019. 6. The DON is currently enrolled in an on-line MDS training program thru AANAC where she will obtain her RAC-CT certification by 1/1/2020. 7. The DON will also be attending a 3 day MDS training in SLC Utah in Jan. 2020 to ensure MDS data is being entered and collected correctly moving forward.	

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F 636	Continued From page 6 causes and contributing factors and risk factors. The "Analysis of Findings" section was blank for all the worksheets. 3. During an interview on 11/7/19 at 8:40 AM the DON stated there was no other place for a comprehensive assessment to be documented, other than the CAT worksheets. She agreed the CAT worksheets did not have an analysis of findings and stated that was an area for additional education to be provided. 4. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2019, by the Centers for Medicare and Medicaid Services showed on page 4-6 "CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined what the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions...Relevant documentation for each triggered CAA describes: causes and contributing factors; The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why it is a problem; Complications affecting or caused by the care area for this resident; Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning..."	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		12/13/19

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F 656	Continued From page 7	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 8 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 medical record review, and staff interview, the facility failed to ensure care was implemented in accordance with the care plan for 2 of 16 sample residents (#1, #9). The findings were: 1. Review of the care plan provided by the facility (undated) showed resident #1 was to receive restorative care including active range of motion daily 5-6 times per week. The following concerns were identified: a. Review of restorative documentation for September 2019 showed documentation only on six days: 9/3, 9/4, 9/10, 9/11, 9/12, and 9/13. b. Review of restorative documentation for October 2019 showed documentation only on 4 days: 10/22, 10/23, 10/24, and 10/28. 2. Review of the care plan provided by the facility (undated) showed resident #9 was supposed to receive restorative care which included passive or active range of motion 20 minutes and "offer 5-6 times weekly." The following concerns were identified: a. Review of restorative documentation for September 2019 showed only six days of documentation: 9/3, 9/4, 9/10, 9/11, 9/12 and 9/13. b. Review of restorative documentation for October 2019 showed no documentation. 3. During an interview on 11/16/19 at 3:19 PM the DON and CNO both stated the restorative aide had been pulled from restorative duties to work	F 656	1. Care plans have been corrected for resident #1 and #9 as of 11/30/2019. 2. Starting 12/2/2019 we have two full time restorative aids that will be working 7 days a week, following the restorative aid plan of cares with each resident. 3. Education provided to restorative aids regarding documentation and following of care plan. This was done 12/5/2019. 4. All residents receiving restorative aid thru our staff will have a care plan that is updated on a monthly basis by the DON or designee and the restorative aid. This was completed on 11/30/2019 and will be ongoing monthly. 5. All CNA care plans will be created to show they are providing some of the restorative care (i.e. walking the residents down to meals, assisting with PROM). Currently our CNA plan of cares only show cares they provide directly. This will be done by 12/13/2019. 6. Restorative aid will go back to a monthly tracking sheet to ensure they are following the plan of care and documenting correctly. This will begin in December and be ongoing. 7. The DON or designee will track the number of times each residents care plan was reviewed and/or updated on a monthly basis along with the number of days restorative care was done with each resident. This will begin in December and be ongoing.	

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F 656	Continued From page 9 the floor due to a staffing shortage in the last one to two months, and confirmed residents were not receiving restorative according to their plans. They stated all restorative care plans had been put on hold in the last week due to staffing.	F 656	8. The DON or designee will update the QAPI committee on the results of her audits and tracking on a monthly basis starting in December 2019.	
F 679 SS=E	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 and staff interview, review of activity attendance records, and review of medical records, the facility failed to provide 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 wellbeing for 3 of 16 sample residents (#6, #8, and #20.) The findings were: 1. Review of the quarterly MDS assessment dated 8/08/19 showed resident #6 was admitted to the facility on 10/31/18. Further review showed the resident required limited assistance and supervision for transfers, bed mobility, walking, and locomotion, and it was "very important" for the resident "to go outside". Review of the	F 679	1. Resident #6,#8 and #20 activities care plan were updated by the activities coordinator to show what the residents are actually doing and what the residents are wanting with the activity program. This was done by 12/2/2019. 2. To ensure that all residents have an input regarding the activities, each resident will be asked what activities they would like to have implemented and this will be documented by the DON or designee by 12/13/2019. 3. The activities coordinator will have a suggestion box by the puzzle table for the residents to be able to suggest activities or recommend changes while staying anonymous. This will be done by	12/17/19

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F 679	Continued From page 10	F 679		

activities care plan last revised on 2/08/19 showed the resident had the potential for self-isolation due to the lack of interest in group activities. Approaches included "Encourage interactions with peers and staff during activities. Encourage [the resident] to attend activities of interest. Invite and assist to activities of interest including visits from friends, watching TV, morning jump start special events, read the newspaper, haircuts, in room crafts and voting." The following concerns were identified:

a. Observation on 11/04/19 from 4:10 PM to 5:15 PM showed the resident was in his/her room, including during meals. Interview with the resident on 11/05/19 at 10:24 AM revealed the resident did not feel there were any activities that s/he could relate to. The resident revealed s/he had been at the facility for "about one year" and felt the facility didn't "have activities" unless the residents "play bingo or balloon volleyball." Further interview revealed the resident "wished they had more outside activities in the community," however, unless residents were able to "find someone to drive" activities outside the facility were not available.

b. Review of the "activity attendance record" for October 2019 showed the resident attended 7 of the 35 activities s/he was invited to attend.

2. Review of the admission assessment dated 9/20/19 showed resident #8 was admitted to the facility on 10/11/19. Further review showed the resident required supervision and set up only for the mobility ADLs of transfer, bed mobility, walking, and other locomotion, and it was "very important" for the resident "to be around animals and pets". Review of the activities care plan dated 9/12/19 showed "social services will schedule weekly 1:1 to observe mood and behavior

12/3/2019.
4. South Lincoln Nursing Center is currently in the process of obtaining a pet for the residents. The activities coordinator will take on providing education to all residents about caring for the pet as well as good hand hygiene. This will be done by week of 12/11/2019 pending the weather.
5. The activities coordinator will plan a minimum of three (3) community activities a month to facilitate residents being able to get out of the facility more. These will be added to the December activities and an updated calendar will be provided to all residents by 12/6/2019.
6. The activities coordinator will place a sign up sheet outside the activity room for residents to sign up for an outing outside of the facility and for individual activities as they wish. This will be done by 12//5/2019.
7. The "Z" shift 8am to 5pm CNA will be educated by the activities director regarding how to lead a staff activity each day of the weekend. This shift will take the responsibility of leading the activity on Saturday and Sunday. This will be completed by 12/13/2019.
7. Documentation of all 1:1's will be present in the charts moving forward. This will be tracked on a weekly basis x1 month starting the week of 12/1/2019 and be ongoing.
8. The activities coordinator is currently enrolled in an activities director certification course thru NCCAP that will provide more education and knowledge into what is needed and required for our

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	53A051	A. BUILDING _____ B. WING _____	11/07/2019

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F 679	Continued From page 11 patterns" and "activities coordinator will invite and encourage resident to join group activities". The following concerns were identified: a. Observation on 11/04/19 at 4:09 PM showed the resident was lying on top of his/her bed, clothed, and asleep. Observation at 6:00 PM showed resident continued to sleep. b. Observation on 11/05/19 from 8:00 AM to 10:51 AM showed the resident was in bed and asleep. c. Interview with the resident on 11/05/19 at 1:03 PM revealed "There are not very many activities, and none that go out into the community." d. Review of the "activity attendance records" for October 2019 showed the resident attended 12 of the 34 activities s/he was invited to attend and there was no evidence of documented 1:1 sessions with social services or activities. 3. Review of the admission MDS assessment dated 6/19/19 showed resident #20 was admitted to the facility on 6/10/19. Further review showed the resident required limited assistance of 1 person for the mobility ADLs of walking, locomotion, transfers, and bed mobility. Review of the activities care plan last revised on 6/10/19 showed the resident had social isolation due to cognitive impairment related to dementia. Approaches included 1 cognitive activity per week for retention of cognitive abilities, 1:1 one time weekly for increase in socialization, and resident encouraged to attend daily activities with social services to evaluate and visit at least quarterly. The following concerns were identified: a. Observation on 11/05/19 from 10:18 AM to 1:12 PM showed the resident remained in bed in the same position on his/her left side. b. Review of the "activity attendance record"	F 679	residents. 9. The DON or designee will ask the residents the following 5 questions between then 10th and 15th of each month to evaluate the appropriateness of the activities being offered A)Are there any scheduled activities that you are interested in B) What's your favorite activity? C) What activity do you dislike the most? D) Is there an activity you would like to see be offered? E) Any suggestions for outings that you would prefer? Survey results will be reviewed with the activity coordinator and implemented when appropriate for the next month. This will begin December 17th and be ongoing. 10. The DON or designee will monitor on the LTC tracking sheet every month that activity care plans will be updated monthly, that 3 community activities are being scheduled monthly, and the number of individual activities each resident requested and completes. This will begin the month of December and be ongoing. The DON will report results to the QAPI committee.	

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F 679	Continued From page 12 for October 2019 showed the resident attended 4 of the 33 activities s/he was invited to, and there was no evidence of documented 1:1 sessions with social services or activities. 4. Interview with the activities coordinator on 11/13/19 at 1:40 PM confirmed the activity program was new to the current activity coordinator and that 1:1 assessments, activities, and social service visits were not being done. Further interview revealed the facility staff had received "very little" training.	F 679		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of consultation reports, the facility failed to provide	F 680	1. South Lincoln Nursing Center will have a contract in place starting 12/20/2019.	1/14/20

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F 680	Continued From page 13 an activities program that was directed by a qualified professional. The findings were: 1. Interview with the activities director on 11/6/19 at 1:40 PM revealed she had been working as the activities director for less than one year, and had no previous experience in a social or recreational program within the last 5 years. She reported that she continued to be trained and assessed by an activities consultant once a month; the consultant reviewed the activities schedule, observed an activity, and evaluated documentation and charting. The responsibilities for the consultant were not sufficient to fill the role of activities director. 2. Interview with the CNO and DON on 11/7/19 at 10:58 AM confirmed that the activities director did not meet the qualifications for the position, but they believed the monthly consultation was sufficient to meet the requirements for an activities director. The reported function of the consultant was to review the activities calendar, review charting, and observe some activity participation one day per month. In a follow-up interview with the CNO on 11/7/19 at 11:18 AM, she confirmed that the consultation reports for September and October were not available because the consultant did not visit the facility or provide direct consultation for either of those months. 3. Review of a consultation report from August 2019 showed results that contradicted the August calendar. The consultant erroneously documented the presence of weekend programs facilitated by the staff and the presence of weekly evening activities that did not exist on the August calendar.	F 680	2. Our Consultant and our activities coordinator will be communicating by phone over the holidays and is scheduled for a two day visit on January 13th and 14th to review what we are currently doing, provide education to our activities coordinator and oversight of our activities program. 3. Our consultant will be coming on a monthly basis to our facility starting January 13th and will also be doing every other week phone calls with the activity coordinator to review and discuss our activities program. 4. Our current activities coordinator is enrolled the activity Director Certification Services thru the NCCAP that will be completed within 6 months. 5. In order to ensure that our activity program is meeting all the needs of our residents, we will review all of the CAT and perform individual interviews with each resident before the consultant arrives and again while the consultant is present so that the program can be restructured as needed to best meet the needs of the residents. This will be done the first time by 12/24/2019 and then again on 1/13/2020. 6. The consultant will type up a report after every phone call and site visit showing what was discussed and what needs to be addressed if anything to our activity coordinator, DON and CNO. This will begin in January and be ongoing. 7. The consultant will receive notification of when all MDS quarterly reports, significant changes, and yearly MDS are due and will then either do them or	

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F 680	Continued From page 14	F 680	delegate them to our current activities coordinator to complete them. This will begin January 2020 and be ongoing. 8. Our consultant will review the activity schedule prior to it going out to our residents and being posted to ensure that we are meeting all of the requirements and the residents needs. This will begin January 2020 and be on going. 9. It will be the responsibility of the DON and activity coordinator to ensure that the consultant upholds the contract and if not will notify the CNO immediately for further actions. 10. The DON or designee will track the consultants visits on the LTC tracking sheet and report them to the QAPI team once a month starting in January.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		12/31/19

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F 688	Continued From page 15 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident interviews, the facility failed to provide restorative nursing services to 2 of 2 sample residents (#1, #9) with range of motion limitations. The findings were: 1. Review of the initial MDS assessment with an assessment reference date (ARD) of 8/12/19 showed resident #1 had range of motion limitations on one lower extremity. Review of the current care plan provided by the facility (undated) showed the resident was to receive restorative care including active range of motion daily 5-6 times per week. Review of a restorative plan dated 9/1/19 showed the resident was to receive active range of motion 3 times per week and lower extremity exercises on the right leg 5 times per week. The following concerns were identified: a. Further review of the care plan showed restorative care was "currently on hold due to staffing." b. During an interview on 11/4/19 at 4:28 PM the resident stated she had been receiving restorative nursing, but that staff person was "taken away to work the floor." c. Review of restorative documentation for September 2019 showed documentation only on six days: 9/3, 9/4, 9/10, 9/11, 9/12, and 9/13. d. Review of restorative documentation for October 2019 showed documentation only on 4 days: 10/22, 10/23, 10/24, and 10/28. e. Review of restorative documentation on 11/6/19 showed no documentation for the month of November 2019 to date. f. Review of the medical record showed the	F 688	1. Restorative aide plan of cares corrected for patients #1 and #9 on 11/30/2019. 2. Effective 12/2/2019 we have two full time restorative aids that will work 7 days a week with each resident according to their restorative aid plan of cares. 3. The new restorative aid will have one month of training with current restorative aid on following plan of care, charting, updating DON on plan of care changes as per residents progress, how to follow monthly schedule, and how to perform scheduled restorative cares safely. This will be done by 12/31/2019. DON will review charting on weekly basis and provide education as needed to restorative aids. This has begun starting 12/9/2019. 3. All residents have the potential for frequent changes to their care plan as their conditions change. The DON or designee will audit the care plans based off the residents needs and monthly meetings set up with the restorative aid to ensure that the residents needs are being met. All residents receiving restorative aid thru our staff will have a care plan that is updated monthly by the DON and restorative aid. This will be completed by 12/3/2019 and be ongoing. 4. All CNA care plans will be created to show the additional activities they are doing with the residents vs just the care portion (i.e. walking residents to and from dining room, performing passive range of	

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F 688	Continued From page 16 resident had also received physical therapy (PT) until 10/24/19. Review of the 10/24/19 PT discharge note showed the plan was to continue working with the restorative aide on strengthening and conditioning. However, review of restorative documentation showed only one day, 10/28/19, of restorative since PT was discontinued. 2. Review of the significant change MDS assessment with an ARD of 9/30/19 showed resident #9 had range of motion limitations to one lower extremity. Review of the significant change MDS with an ARD of 10/30/19 showed the range of motion remained the same (limitation on one lower extremity). Review of the current care plan provided by the facility (undated) showed the resident was supposed to receive restorative care which included passive or active range of motion 20 minutes and "offer 5-6 times weekly." The following concerns were identified: a. Further review of the care plan showed restorative was "currently on hold due to staffing." b. Review of restorative documentation for September 2019 showed only six days of documentation: 9/3, 9/4, 9/10, 9/11, 9/12 and 9/13. c. Review of restorative documentation for October 2019 showed no documentation. d. Review of restorative documentation on 11/6/19 for November 2019 showed no documentation to date. e. Review of the medical record showed the resident was receiving PT until 10/21/19 when it was discontinued. Previous review of restorative documentation showed no restorative was provided since PT was discontinued. 3. During an interview on 11/16/19 at 3:19 PM the DON and CNO both stated the restorative aide	F 688	motion). This will be completed by 12/5/2019 and be reviewed on a monthly basis or as residents needs change. 5. The DON or designee will track the restorative aide plan of cares and the CNA care plan updates on the LTC QA tacking sheet on a monthly basis and report to QAPI committee monthly starting in December 2019.	

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F 688	Continued From page 17 had been pulled from restorative duties to work the floor due to a staffing shortage in the last one to two months. They further stated they recently (in the last week) put all restorative care plans on hold due to the staffing issues.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §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 medical record review, staff interview, and review of facility policies, the facility failed to ensure a comprehensive nutritional assessment was completed, and failed to ensure the registered dietitian (RD) was consulted for 1 of 3 sample residents (#9) with weight loss. The findings were:	F 692	1. South Lincoln Nursing Center has signed an agreement with IHC that they will provide the required dietician services for both our hospital and nursing center. Contract was signed on 11/22/2019 and the onsite visit occurred on 11/22 and 11/23/19.	12/13/19

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F 692	Continued From page 18 1. Review of the 9/30/19 significant change MDS assessment showed resident #9 was readmitted to the facility on 9/20/19 from the hospital. The diagnoses included urinary tract infection (UTI), hip fracture, and unspecified dementia. Review of a 10/15/19 physician's note showed the resident recently had a significant decline in mental status and the dementia was progressing. The note also said the resident had a decline in his/her current condition and had a UTI, which was being treated with IV [intravenous] Vancomycin. Review of the 10/30/19 significant change MDS assessment showed the resident had experienced a significant weight loss. Review of weights in the medical record showed on 9/24/19 the resident weighed 129.6 pounds, and on 10/28/19 the resident weighed 108 pounds, which was a 16.67% loss. Review of facility documentation showed the skin and nutritional risk committee had been monitoring the resident weekly. Review of the care plan and interview with the certified dietary manager (CDM) on 11/6/19 at 2:51 PM revealed since the weight loss, the facility changed the diet (to ground meats), added protein packs to all meals, provided adaptive equipment, and moved the resident to the assisted dining table to receive assistance from staff with meals. The CDM further stated she felt the weight loss was due to disease progression and decline since the hip fracture. The following concerns were identified: a. Review of the significant change MDS assessment, with an assessment reference date of 10/30/19, showed nutritional status triggered. Review of the "CAT Worksheet" for nutritional status showed it was not a comprehensive assessment. Although there were checkmarks for some indicators, there lacked an analysis of	F 692	2. CAT worksheet for resident #9 was fixed to show the concerns as documented by the CDM reflecting disease process this was done on 12/5/2019. 3. All residents at risk for weight loss to affect their plan of care. All resident CAT worksheets reviewed by MDS and DON to ensure appropriate documentation was done. This was completed by 12/13/2019. 4.The CDM now has access to the MDS for nutritional assessments and will be working with our new Registered Dietician to ensure that all quarterly, significant changes and new assessments are done with the correct documentation in the CAT worksheet filled out. All recommendations from the RD will be followed up on and completed within 24 hrs of receiving the recommendations. 5. The CDM was educated by the RD regarding how to complete the assessments appropriately and document correctly. This was completed on 11/23/2019. 6. The RD completed care plans on all 23 residents, did one nutritional assessment that the CDM had not done and reviewed all 22 residents nutritional assessment on their onsite visit 11/22 and 11/23/2019. 7. The CDM and DON are meeting on a weekly basis (currently every Tuesday0 to review the nutrition concerns of all residents. This was started on 11/19/2019 and will be ongoing. 8. The RD provided education to the CDM on 11/22/2019 regarding hand washing, glove use, when to discard food, and checking internal food temps. This was all	

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F 692	Continued From page 19 findings to describe the problem, and identify possible causes and contributing factors and risk factors. The "Analysis of Findings" section was blank in the worksheet. Review of the medical record showed no evidence of a comprehensive assessment since the resident's significant weight loss. The last nutritional assessment ("medical nutritional therapy review") completed by the RD was dated 1/8/19. The last "nutritional assessment" was dated 4/10/19 and was completed by the CDM. b. Further review of the medical record showed no evidence the RD was consulted regarding the weight loss. During an interview on 11/6/19 at 2:51 PM the CDM and DON stated the consultant RD "was notified" but stated since he turned in his notice (to discontinue consultant work), he had "very little involvement." They confirmed there had been no nutritional assessment completed since the weight loss. c. Review of the facility policy "Dietary. Clinical Documentation. Nutritional Documentation" (approved 12/13/18) showed "...A new nutritional assessment is completed each time a resident is re-admitted, has a significant change in condition, and as deemed necessary by federal and state guidelines of the RD."	F 692	done on 11/22/2019. 9. All residents most recent CAT worksheets will be reviewed for accuracy and completion by 12/13/2019. 10. The DON or designee will track all RD recommendations and the completion date of the task on the QA LTC tracking sheet every month. This will begin in November and be ongoing monthly. This will be reported to the QAPI committee monthly starting in December. 11. Shared folders were placed on the desktop for the DON, CDM that allows the weights in an eliminate formula mess ups. The RD liked these forms and recommended a couple of changes to the CDM. These changes will be done by 12/10/2019 with their next visit.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 697		12/13/19

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F 697	Continued From page 20 by: Based on medical record review, staff and resident interview, and policy review, the facility failed to consistently assess pain for 1 of 1 residents (#2) who reported high pain levels. The findings were: 1. Interview with resident #2 on 11/5/19 at 9:55 AM revealed the resident was concerned about his/her pain not being managed effectively with medications. S/he reported frequent pain levels of 10/10, even after administration of pain medications. The following concerns were identified: a. Review of pain assessments from 10/1/19 to 10/31/19 showed 18 days in which pain assessments were not conducted for the resident. b. Review of the care plan showed "Evaluate [the resident]'s pain daily using 1-10 scale." c. Interview with the DON on 11/6/19 at 11:23 AM revealed the list of pain assessments was accurate and there were no other assessments to account for the missing days. d. Review of "Resident Pain Assessment and Control" policy revised 2/7/06 showed "...At each medication pass time the charge nurse will ask the residents if they are experiencing pain and then document it on the pain management flow sheet..."	F 697	1. Resident #2 has had a pre and post pain assessment attached to all of his current scheduled and prn pain medications. The pre pain assessment is done at the time of administration and the post pain assessment is done one (1) hour after medication is administered. This was done on 11/6/2019. 2. The DON went thru all of the residents orders and made sure that with any pain medications the pre and post pain assessment was attached to the pain medications. This was completed on 11/8/2019. 3. The DON did an in-service on pain management on 11/8/2019 with all CNA and nurses providing education on pain management. 3. The DON is currently working with AHT to build a weekly pain assessment tool in the LTC electronic health record to ensure that there is a weekly pain assessment being done on all residents receiving pain medication on a weekly basis. This will be done by 12/13/2019. 4. DON or designee will track weekly pain assessments are being done on our LTC QA tracking sheet along with pre and post pain assessments being documented when a resident is receiving pain medications. This will be tracking on a monthly basis starting in December and be ongoing with reports given to the QAPI committee on a monthly basis starting in December.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		12/20/19

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F 725	Continued From page 21 §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 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 medical record review, staff and resident interviews, and review of facility documentation, the facility failed to ensure sufficient staff to provide care in accordance with the care plan for 2 of 2 sample residents (#1, #9) who had care plans for restorative. In addition, the facility's insufficient staff affected another 17 residents (#4, #5, #6, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23) who	F 725	1. Currently long term care has hired eight (8) new staff members in the last month and twenty two (22) in the last 6 weeks who are all on a 3 week orientation. Once everyone is done with the orientation staffing will be more than adequate again. 2. Once adequate staff is present, then we will go back to having two (2)	

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	53A051	A. BUILDING _____ B. WING _____	11/07/2019

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F 725	Continued From page 22 also had restorative care plans. The findings were: 1. Review of the initial MDS assessment with an assessment reference date (ARD) of 8/12/19 showed resident #1 had range of motion limitations on one lower extremity. Review of the current care plan provided by the facility (undated) showed the resident was to receive restorative care including active range of motion daily 5-6 times per week. Review of a restorative plan dated 9/1/19 showed the resident was to receive active range of motion 3 times per week and lower extremity exercises on the right leg 5 times per week. The following concerns were identified: a. Further review of the care plan showed restorative care was "currently on hold due to staffing." b. During an interview on 11/4/19 at 4:28 PM the resident stated she had been receiving restorative nursing, but that staff person was "taken away to work the floor." c. Review of restorative documentation for September 2019 showed documentation only on six days: 9/3, 9/4, 9/10, 9/11, 9/12, and 9/13. d. Review of restorative documentation for October 2019 showed documentation only on 4 days: 10/22, 10/23, 10/24, and 10/28. e. Review of restorative documentation on 11/6/19 showed no documentation for the month of November 2019 to date. f. Review of the medical record showed the resident had also received physical therapy (PT) until 10/24/19. Review of the 10/24/19 PT discharge note showed the plan was to continue working with the restorative aide on strengthening and conditioning. However, review of restorative documentation showed only one day, 10/28/19, of	F 725	restorative aids that will work 7 days a week alternating to provide specific cares to the residents focusing on range of motion and/or mobility along with some other activities focusing on fine motor skills. This will be completed by December 13, 2019. 3. The CNA plan of cares will include restorative aid specific activities to ensure that if we do not have an Restorative Aid the activities will still occur for the residents. This will be done by 12/20/2019. 4. The DON or designee will continue to track the staffing in the long term care department to ensure adequate staffing along with being able to keep the restorative aids on the floor. This will be tracked on the QA tracking sheet and reported to the CNO on a monthly basis.	

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F 725	Continued From page 23	F 725		

restorative since PT was discontinued.

2. Review of the significant change MDS assessment with an ARD of 9/30/19 showed resident #9 had range of motion limitations to one lower extremity. Review of the significant change MDS with an ARD of 10/30/19 showed the range of motion remained the same (limitation on one lower extremity). Review of the current care plan provided by the facility (undated) showed the resident was supposed to receive restorative care which included passive or active range of motion 20 minutes and "offer 5-6 times weekly." The following concerns were identified:

a. Further review of the care plan showed restorative was "currently on hold due to staffing."

b. Review of restorative documentation for September 2019 showed only six days of documentation: 9/3, 9/4, 9/10, 9/11, 9/12 and 9/13.

c. Review of restorative documentation for October 2019 showed no documentation.

d. Review of restorative documentation on 11/6/19 for November 2019 showed no documentation to date.

e. Review of the medical record showed the resident was receiving PT until 10/21/19 when it was discontinued. Previous review of restorative documentation showed no restorative care was provided since PT was discontinued.

3. During an interview on 11/16/19 at 3:19 PM the DON and CNO both stated the restorative aide had been pulled from restorative duties to work the floor due to a staffing shortage in the last one to two months. They stated they had a "staffing crisis" and needed to pull the restorative aide to work the floor to ensure there were always two CNAs on the floor. They further stated they

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F 725	Continued From page 24 recently (in the last week) put all restorative care plans on hold due to the staffing issue. They stated they have advertised for staff, have increased wages, and have a CNA class in progress and so they were hoping to reinstate restorative in December. 4. Review of documentation provided by the facility showed the following additional residents had restorative care plans which were currently on hold due to staffing: #4, #5, #6, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, and #23.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		11/30/19

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F 755	Continued From page 25 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure medications were not expired in 1 of 2 medication storage areas surveyed (medication room). The findings were: 1. Observation of the bulk medicine storage room on 11/05/19 at 9:38 AM showed a multi-dose vial of injectable tuberculin protein in use which had expired on 7/18/19, and 5 plastic one-time use vials of albuterol sulfate which were labeled with an expiration date of July 2019. 2. Interview with pharmacy staff member #1 on 11/05/19 at 9:38 AM revealed the expectation of the facility was for outdated medications and biologicals to be removed from the storage area so they were not available for resident use.	F 755	1. The TB multi-dose vial along with the albuteral vials were removed from the medication room on 11/5/2019 by the pharmacy tech. 2. The pharmacist and/or pharmacy tech will go thru the medication cart and medication room the last day of every month to ensure that all outdates are removed. This will start in November 2019 and be ongoing. 4. This tag was corrected on 11/30/2019 with walk through and no expired medications present in the long term care. 3. South Lincoln Nursing Center will no longer have multi-dose vials in their fridge, if a new resident comes in the DON or designee will go to the pharmacy and draw up the required amount of medication. This will start in December and be ongoing. 4. The DON or designee will track on the LTC QA tracking sheet that monthly medication outdates have been done and that their are no multi-dose vials in the fridge. This will begin in December and be ongoing. 5. The DON or designee will report the results to the QAPI committee on a	

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F 755	Continued From page 26	F 755	monthly basis starting in December.	
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: Based on medical record review, staff interview, and review of policy, the facility failed to implement an infection prevention and control program with antibiotic use protocols and a system to monitor antibiotic use for 1 of 1 sample resident (#18) with prophylactic antibiotics. The findings were: 1. Review of the change of condition MDS assessment dated 11/06/19 showed resident #18 admitted to the facility on 7/27/18 with diagnoses which included atrial fibrillation, hypertension, hypothyroidism, arthritis, depression, unspecified pain, polyneuropathy, and irritable bowel syndrome. Further review showed Section I of the assessment indicated the resident had not had a UTI within the last 30 days. Review of the November 2019 physician's orders showed the resident had an order for macrodantin 100 mg by mouth daily ordered July 2018. Review of a pharmacy note dated 9/25/19 showed there were no signs and symptoms of infection and the culture report indicated "non-significant	F 881	1. Resident #18 provider was educated on when a prophylactic antibiotic is started that it needs to be documented in their chart along with the reason why. This was corrected on 11/14/2019 provider note. 2. Two addition residents were identified as needed a providers note to justify their prophylactic antibiotic and the DON provided education to the providers regarding prophylactic antibiotic and the need to document the justification in the residents chart. This was done on 11/6/2019. 3. All residents have the potential to be effect by antibiotic use going forward. At the end of every month the DON or designee will review medications and converse with provider on any antibiotic use, if needed providers will document rationale in the residents chart. This will be a monthly thing starting November 2019 and be ongoing. 4. The DON will continue to track all	11/14/19

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F 881	Continued From page 27 organism". The following concerns were identified: a. Review of the medical record showed there was no evidence of a recent urine culture or documentation of active infection noted. 2. Interview with the pharmacist on 11/7/19 at 8:21 revealed medication reviews should include the use of antibiotics and it was confirmed an order stating "macrobid for prophylaxis for UTI" does not constitute a justification for continued use. 3. Review of policy titled "Tracking Infection" dated 12/15/18 showed "When a resident is thought to have an infection (UTI, skin, eye, URI) the nurse will use the McGeer criteria to check off the symptoms the residents are having and contact the physician. If the resident needs to seen by the provider, an appointment will be scheduled down in the clinic and the resident will be accompanied to the appointment by either the nurse, CNA, or DON. An antibiotic will not be started for a UTI until the urine culture is back in an attempt to prevent bacteria resistance unless specified by the provider due to the resident's symptoms. All cultures will be tracked by the DON and the provider will be updated with the results as soon as they arrive so that the proper antibiotic may be started." 4. Review of the policy titled "South Lincoln Medical Center Pharmacy and Therapeutics/Antibiotic Stewardship" updated 11/5/19 showed "The Pharmacy and Therapeutics/Antibiotic stewardship committee is organized for the purpose of reviewing current standards and practices, discussing issues, opportunities, needs, initiatives, etc., facilitating training, or determining and implementing new or	F 881	infections throughout the nursing home, ensuring that a McGeer criteria was completed, that cultures are back prior to starting the resident on an antibiotic or that if an antibiotic was started that it was the right antibiotic. 5. The Pharmacist will continue to do monthly MTM reviews on all residents in the nursing center and verify if one is on an antibiotic that there is a justification documented in their chart or recommend that the medication be stopped. 6. The DON or designee will continue to track that monthly MTM's are occurring on all residents and will also track if any resident is on a prophylactic antibiotic that there is justification in the chart. This will be done on a monthly basis starting in December and be ongoing. The DON or designee will report the results to the QAPI committee on a monthly basis starting in December 2019. 7. The Pharmacist will continue to have monthly antibiotic stewardship meetings with the committee to ensure that we are reviewing our standards and have best practices in place. The Pharmacist and CNO are currently working with Wyoming Coalition Team to strengthen the current antibiotic stewardship program. 8. The DON will document on the LTC tracking sheet the number of residents who are on antibiotics, is there a justification as to way documented by the physician and is there a stop date ordered. This will begin the month of November and be ongoing. 9. The CNO will track that the antibiotic stewardship committee meets on a	

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F 881	Continued From page 28 updated policies and procedures. These activities are conducted with the express purpose of advancing initiatives, process improvements, updates to regulatory practices, and monitoring all safety aspects related to conducting business and patient care."	F 881	monthly basis and will report this to the QAPI committee on a monthly basis starting in December.	