STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	12/05/2019

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THE LEGACY LIVING AND REHABILITATION CENTER	1000 S DOUGLAS HWY GILLETTE, WY 82716

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 12/2/19 through 12/5/19. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing Services MDS: Minimum Data Set MAR: Medication Administration Record RN: Registered Nurse TAR: Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, 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 29 sample residents (#62, #124). The findings were: 1. Review of the 10/4/19 quarterly MDS assessment showed resident #62 had diagnoses which included delirium due to known psychological condition, vascular dementia without behavioral disturbance, adjustment	F 641	Correction for cited residents: Resident #62 1. MDS correction was completed on 12/20/19. Resident #124 2. MDS correction was completed on 12/4/19. Identification of other residents: The facility will review all MDS assessments completed within last 30 days to ensure accurate reflection of the resident status.	1/19/20

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

Electronically Signed | 12/23/2019

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F 641	Continued From page 1 disorder with depressed mood, iron deficiency anemia, gastro-esophogeal reflux disease, type 2 diabetes mellitus without complications, and long term use of antibiotics. Further review showed the resident was coded for significant weight loss and significant weight gain. Review of the 7/4/19 quarterly MDS assessment showed the resident had been coded for no weight loss and no weight gain. The following concerns were identified: a. Review of the resident's weights showed the resident had a 3% weight gain in 30 days (9/4/19 to 10/2/19) prior to the 10/4/19 quarterly MDS assessment, 0.49% weight gain in 90 days (8/7/19 to 10/2/19) prior to the assessment, and an 11.08% weight loss in 120 days (4/3/19 to 10/2/19) prior to the assessment. Further review showed the resident had an 8.63% weight loss in 30 days (5/22/19 to 6/26/19) prior to the 7/4/19 quarterly MDS assessment. b. Interview with the MDS coordinator on 12/5/19 at 9:33 AM revealed after she reviewed the documented weights, she felt the weight loss should have been coded on the 7/4/19 quarterly MDS and she was unsure why both weight loss and weight gain were coded on the 10/4/19 quarterly MDS assessment. c. Interview with nutrition technician #1 on 12/5/19 at 9:52 AM revealed the resident was coded as a weight gain, on the 10/4/19 quarterly MDS assessment, in error. d. Review of the "CMS RAI version 3.0 manual, October 2019, showed "...K0300: weight loss...DEFINITIONS 5% WEIGHT LOSS IN 30 DAYS Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight.	F 641	Systematic changes and Monitoring: Education provided to all staff by 1/19/20 regarding accuracy of MDS coding. Education provided to MDS team by 1/19/20 regarding accuracy of MDS coding. Review and revisions of policy, Minimum Data Set (MDS) 3.0. Review and revision of policy, Weight monitoring. Review and revision of policy, Restraints. Outcome: All MDS assessments within the last 30 days will demonstrate accurate reflection of resident status. A monthly audit of 15 (10%)residents will be completed to monitor the systemic changes. 100% of residents will have accurate MDS coding of assessments, reflective of resident status, which will be collected by Director of Nursing (or designee). Results will be aggregated and reported monthly at long term care quality meetings. All discrepancies will be investigated, corrected and reported.	

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F 641	Continued From page 2	F 641		

10% WEIGHT LOSS IN 180 DAYS Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight...Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician...If the resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status..."

2. Review of the 11/6/19 quarterly MDS assessment showed resident #124 required limited assistance with 1 person physical assist for bed mobility and transfers. Further review of the assessment showed the resident had a bed rail restraint used daily. Observation on 12/02/19 at 3:59 PM showed the resident had 2 bed rails that were approximately 1/2 the length of the bed. The following concerns were identified:

a. Review of the 11/3/19 skilled evaluation showed the resident did not have any physical restraints, and the bed rails were an assistive device.

b. Interview with the DON on 12/4/19 at 12:24 PM revealed the bars on the bed were not restraints, they did not have any gaps that would pose entrapment risk, and they were assessed as mobility aides. She confirmed the MDS assessment information had been coded inaccurately.

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		1/19/20

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F 656	Continued From page 4 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to develop a comprehensive person-centered plan of care for 3 of 29 residents (#15, #125, #131). The findings were: 1. Review of the quarterly MDS assessment dated 11/6/19 showed resident #125 had diagnoses which included peripheral vascular disease, depression, morbid obesity, alcohol dependence, insomnia, and polyneuropathy and a BIMS (brief interview for mental status) score of 14 (cognitively intact). Further review showed the resident required extensive assist or higher with all ADLs, with the exception of eating and did not identify edema as an area of concern. Review of the care plan showed the resident had little to no interest in group activities, and would only like to be invited to special, large events. The following concerns were identified: a. Interview with the resident on 12/3/19 at 10:40 AM, revealed the resident had frequent swelling in his/her lower legs and wore PODUS boots (a multi-purpose, padded foot boot utilized in the healing/prevention of heel/toe ulcers and safeguards against foot drop) "almost all of the time." Observation at that time showed the resident's legs were swollen and appeared to have indentations left in his/her legs that were possibly made by the PODUS boots. b. Review of the resident's current medication orders showed a 9/25/19 order for "PODUS Boots to bilateral feet." There were no directions specified for the order. Review of the November	F 656	Correction for cited residents: Resident #15 1. Care plan correction regarding the following: edema care interventions as ordered by the provider. Resident #125 2. Care plan correction regarding the following: physician assessment for edema care, clarification of podus boot order, and provision of preferred activities. Resident #131 3. Care plan correction regarding the following: foot drop interventions as ordered by the provider. Identification of other residents: The facility will review comprehensive person centered care plans completed in the last 30 days to ensure inclusion of measurable objectives and timeframes to meet a residents' medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. Systematic changes and Monitoring: Education provided to staff by 1/19/20 regarding developing and implementing a comprehensive plan of care. Review and revisions of policy, Care Planning. Review and revisions of policy, Activity Assessment/Evaluation. Review and revisions of policy, Activity One to One Visits.	

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F 656	Continued From page 5 and December 2019 MARs (medication administration record) and TARs (treatment administration record) showed no documentation of the implementation of the order. Further review showed these records did not identify any medications that the resident was taking to address the identified swelling, or supporting documentation of the PODUS boot implementation. c. Review of an activity note dated 8/22/19 and timed 2:24 PM showed activity preferences were discussed with the resident and the resident stated s/he no longer needed 1 to 1 visits and the resident was "...content with watching [his/her] tv [television] and eating [his/her] snacks. 1-1 visit [sic] will be decreased to as needed and will continue to monitor for any concerns." d. Review of the care plan last reviewed on 11/25/19 showed the care plan did not address the issues with swelling for the resident. Further review showed there were no interventions reflected on the plan of care related to edema and no interventions which reflected the resident's 1 to 1 activity needs or monitoring for changes noted on the 8/22/19 activities note. e. Interview with the activity director and activity assistant #1 on 12/4/19 at 11:52 AM revealed the next activity interest evaluation for the resident was scheduled for 2/6/20 and the care plan would be updated when the evaluation was completed. f. Interview with the DON on 12/04/19 at 4:42 PM confirmed the care plan lacked interventions to reduce edema and revealed interventions should be included on the care plan. 2. Review of the annual MDS dated 8/23/19, for resident #15 showed the resident was admitted on 12/3/17 and had diagnoses which included	F 656	Review and revisions of policy, Resident Quality of Life. Outcome: Comprehensive care plans completed within the last 30 days will be audited 100% and any discrepancies corrected immediately. A monthly audit of 15 (10%)residents will be completed to monitor the systemic changes. 100% of residents will have an individualized care plan reflecting the appropriate interventions. This data will be collected by Director of Nursing (or designee). Results will be aggregated and reported at long term care quality meetings. All discrepancies will be investigated and reported.	

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coronary artery disease, diabetes melitus, and heart failure. Review of the MAR for December 2019 showed an order for furosemide 80 milligrams (mg) (diuretic) in the morning. Review of the physician order dated 10/9/19 showed an order to "elevate feet daily, weekly weights, and to apply ace wraps, on in the AM & off in the PM." The following concerns were identified:

a. Review of the care plan showed no evidence of interventions to reduce edema as ordered by the physician.

b. Review of the December 2019 MAR and TAR showed no evidence of interventions to reduce the resident's edema.

c. Interview with the DON on 12/04/19 at 4:42 PM revealed the care plan lacked interventions to reduce edema and they should be on the care plan.

3. Review of the quarterly MDS assessment dated 11/8/19 showed resident #131 was admitted on 9/9/14 with diagnoses which included hypertension, heart failure, peripheral vascular disease, diabetes mellitus and ESRD (end stage renal disease). Review of the physician order dated 10/9/19 showed "Off load pressure to right foot with PODUS [multi-purpose, padded foot boot utilized in the healing/prevention of heel/toe ulcers and safeguards against foot drop] boot at all time." Observation on 12/4/19 at 11:31 AM showed the resident was in the wheelchair without a PODUS boot on the right foot. The following concerns were identified:

a. Review of the care plan showed no evidence of interventions to protect the resident's right foot as ordered by the physician.

b. Interview with the DON on 12/4/19 at 3:55 PM confirmed the order for the boot, and further confirmed the care plan did not include

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F 656	Continued From page 7 interventions.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to develop a care plan based on the comprehensive assessment for 1 of 29 sample residents (#126). The findings were:	F 657	Correction for cited residents: Resident #126 1. Care plan correction regarding the following: pain identified as a problem area and applicable interventions specific	1/19/20

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F 657	Continued From page 8 Review of the 11/7/19 quarterly MDS assessment showed resident #126 was coded as having frequent pain which limited day-to-day activities. Review of the 8/7/19 significant change MDS assessment showed the resident triggered for pain. The care area assessment (CAA) showed the resident had occasional neck pain with a severity of 7/10, which did not interrupt sleep or limit daily activities. A decision was shown to continue to care plan. Review of the November and October 2019 MARs (medication administration record) showed the resident received scheduled and as needed (PRN) pain medications which were shown to be effective for treatment of the pain. The following concerns were identified: a. Review of the care plan showed pain was not identified as a problem area and there were no interventions. b. Interview with the DON on 12/5/19 at 9:48 AM revealed pain was not included on the care plan, the facility had changed the system, and pain should have been included in the care plan.	F 657	to the resident. Identification of other residents: The facility will review comprehensive care plans completed within the last 30 days to ensure they are developed within 7 days after completion of the comprehensive assessment and are interdisciplinary. Systematic changes and Monitoring: Education provided to staff by 1/19/20 regarding care plan timing and revision. Review and revisions of policy, Care Planning. Review and revisions of policy, Pain Management. Outcome: Comprehensive care plans completed within the last 30 days will be completed within 7 days and are interdisciplinary. Any discrepancies will be corrected immediately. A monthly audit of 15 (10%)residents will be completed to monitor the systemic changes. 100% of residents will have a timely individualized care plan reflecting the appropriate interventions. This data will be collected by Director of Nursing (or designee). Results will be aggregated and reported at long term care quality meetings . All discrepancies will be investigated and reported.	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities.	F 679		1/19/20

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F 679	Continued From page 9 §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to provide ongoing, resident-centered activities for 1 of 1 sample residents (#125) identified with activity needs. The findings were: 1. Review of the quarterly MDS assessment dated 11/6/19 showed resident #125 had diagnoses which included peripheral vascular disease, depression, morbid obesity, alcohol dependence, insomnia, and polyneuropathy, and had a BIMS score of 14 (cognitively intact). Interview with the resident on 12/03/19 at 10:03 AM revealed s/he preferred to eat meals in his/her room. Interview with RN House Supervisor #1 on 12/4/19 at 11:24 AM revealed the resident rarely left his/her room or her bed, with the exception of toileting and bathing; the resident was identified as being "bed-bound." Review of an activity note dated 8/22/19 and timed 2:24 PM showed the care plan was discussed with the resident related to activity preferences and the resident stated s/he no longer needed 1 to 1 visits and the resident was "... content with watching [his/her] tv [television] and eating [his/her] snacks. 1-1 visit will be decreased to as needed and will continue to	F 679	Correction for cited residents: Resident #125 1. Resident activity preference assessment and care plan update reflecting resident individual needs completed on 12/12/19. Identification of other residents: The facility will review all comprehensive assessment, care plan and preferences for each resident completed within the last 30 days for ongoing resident centered activities. The comprehensive assessment and care plan will reflect preferences and ongoing documentation to support residents in their choice of activities. Systematic changes and monitoring: Education provided to staff by 1/19/20 regarding care plan timing and revision. Review and revisions of policy, Activity Assessment/Evaluation. Review and revisions of policy, Activity One to One Visits. Review and revisions of policy, Resident Quality of Life.	

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F 679	Continued From page 10 monitor for any concerns." The following issues were identified: a. Interview with the activity director and activity assistant #1 on 12/05/19 at 11:52 AM revealed the resident required 1 to 1 activity sessions due to his/her lack of interest in activities, all staff and volunteers were expected to invite the resident to the activities, the next annual activity evaluation for the resident was scheduled for 2/6/2020 and the care plan would be updated when the evaluation was completed. Further interview revealed updates occur annually, unless a significant change occurred. It was confirmed there was no documentation to support the monitoring of the resident's activity preferences or satisfaction since the changes identified in the 8/22/19 note. b. Review of the activities care plan last revised on 10/16/19 showed the resident required assistance to activities and preferred in-room leisure activities. The plan also included his/her preference to be invited to large group activities; however, the care plan failed to show an approach to address the resident's identified 1:1 needs or continued monitoring. c. Review of monthly activities calendars from 10/01/19 to 12/31/19 for the resident's unit showed there were daily out-of-room activity options for 92 of 92 days; however, the provided documentation showed the resident was invited/encouraged to attend activities on 6 of 92 days, 10/15/19, 10/16/19, 10/18/19, 10/21/19, 10/25/19, and 12/4/19. Further review showed only one occurrence where a 1:1 activity was offered or performed with the resident; on 10/18/19 at 5 PM.	F 679	Outcome: The comprehensive assessment,care plan and preferences for each resident completed within the last 30 days will demonstrate resident centered activities. Any discrepancies will be corrected immediately. A monthly audit will be completed related to comprehensive assessment, care plan and preferences for each resident with a sample size of 15 charts (10%). 100% of residents identified in the monthly audit will have an individualized care plan reflecting the appropriate resident centered activity preferences. This data will be collected by Director of Nursing (or designee). Results will be aggregated and reported at long term care quality meetings. All discrepancies will be investigated and reported.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		1/19/20

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of the medical record, the facility failed to effectively assess and monitor identified care issues for 3 of 29 sample residents (#15, #124, #125). The findings were: 1. Observation on 12/3/19 at 11:45 AM showed resident #124 was awake in bed and had his/her arms and shoulders partially exposed. The resident's left shoulder was noted to have bruising covering the majority of the shoulder. The resident's right inside forearm was also noted to have a bruise. The resident was not interviewable, but was able to express s/he was fine at that time and did not need anything. The following concerns were identified: a. Review of the medical record showed the resident had falls on 12/3/19 and 11/19/19. Review of these fall reports showed there were no injuries and the skin was within normal limits, no bruising was identified. Additionally, there was no mention of bruising to the resident in progress notes or else where in the medical record. b. Interview with the DON on 12/4/19 at 3:38 PM confirmed there was no documentation in the record related to the bruises and an assessment was done that day. She further stated the bruising	F 684	Correction for cited residents: Resident #15 1. Care plan correction regarding the following: edema care interventions as ordered by the provider. Resident #124 1. Skin assessment completed on 12/4/19 at 2:20 pm. Current care plan in place regarding resident□s susceptibility to bruising due to disease process. Resident #125 1. Care plan correction regarding the following: physician assessment for edema care and clarification of podus boot order. Identification of other residents: The facility will review all comprehensive assessment of residents within the last 30 days to ensure that resident receive treatment and care in accordance with professional standards of practice include a comprehensive person centered care plan and resident choice. Systematic changes and Monitoring: Education provided to staff by 1/19/20	

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F 684	Continued From page 12 was thought to be from a previous fall and the assessment and documentation of the bruising should have been completed when the injury occurred. c. Review of the "COMS-Skin Only Evaluation" dated 12/4/19 and timed 2:20 PM showed the resident had 4 areas identified: bruise on the Left shoulder, Left bicep, Right bicep, and a scratch to the Left buttock. The bruises did not include measurements, the scratch was shown to be 1 inch. The narrative showed these bruises were "older bruising, not painful to the resident. Resident is a fall risk with recent fall occurring 12/3/19 and fall on 11/20/19 [actually occurred on 11/19/19]. Resident reports no pain or discomfort...Resident is unable to control movement due to chorea movements from Huntington's." 2. Review of the quarterly MDS assessment dated 11/06/19 showed resident #125 had diagnoses which included peripheral vascular disease, depression, morbid obesity, alcohol dependence, insomnia, and polyneuropathy and a BIMS score of 14 (cognitively intact). Further review showed the resident required extensive assist or higher with ADLs, with the exception of eating. There was no evidence of edema noted. The following concerns were identified: a. Observation on 12/03/2019 at 10:40 AM showed the resident had swelling in his/her lower legs. The resident had PODUS boots (a multi-purpose, padded foot boot utilized in the healing/prevention of heel/toe ulcers and safeguards against foot drop) in place. He/she stated he/she wears them to help the swelling, and wears them "almost all the time." The observation also showed what appeared to be indentations left in his/her legs that were possibly	F 684	regarding resident quality of life Review and revisions of policy, Care Planning. Review and revisions of policy, Resident Quality of Life. Review and revisions of policy, Wound and Skin Precautions/Care/Pressure Ulcer Prevention. Outcome: Based on the comprehensive assessment,all residents in the last 30 days will receive treatment and care in accordance with professional standards of practice, have a comprehensive person centered care plan and reflects resident choice. A monthly audit will be completed using a sample size of 15 (10%) based on the comprehensive assessment, receive care and treatment in accordance with professional standards of practice, have a comprehensiveperson centered care plan and reflective of resident choice. 100% of residents identified in the monthly audit will have an individualized person centered care plan reflecting the appropriate interventions and provider orders. This data will be collected by Director of Nursing (or designee). Results will be aggregated and reported at long term care quality meetings. All discrepancies will be investigated, corrected and reported.	

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F 684	Continued From page 13	F 684		

made by the PODUS boots. Interview with the resident, at that time, revealed the swelling was normal, and his/her legs have been much worse. Further interview revealed s/he "takes a pill to help them, but can't remember what it's called."

b. Review of the physician's orders for December 2019 showed an order dated 9/25/19 for "PODUS Boots to bilateral feet." No directions for use were indicated. Review of the November and December 2019 MAR and TAR showed no documentation of the implementation of the order. Further review showed no evidence of medications which were indicated as treatment for edema or documentation of implementation of the PODUS boot.

c. Review of the care plan revised on 11/25/19 showed the care plan did not reflect a plan to address the issues with swelling for the resident. Further review showed no interventions, including the PODUS boots, were reflected on the care plan.

d. Interview with the DON on 12/04/19 at 4:42 PM revealed the care plan lacked interventions to reduce edema.

3. Review of the annual MDS assessment dated 8/23/19 showed resident #15 was admitted on 12/3/17 and had diagnoses which included coronary artery disease, diabetes melitus, and heart failure. Review of the MAR for December 2019 showed an order for furosemide 80 milligrams (mg) (diuretic) in the morning. Review of the physician orders dated 10/9/19 showed an order to "elevate feet daily, weekly weights, and to apply ace wraps, on in the AM & off in the PM." The following concerns were identified:

a. Review of the care plan showed no interventions to reduce edema as ordered by the physician.

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F 684	Continued From page 14 b. Review of the December 2019 MAR and TAR showed no evidence of interventions to reduce the resident's edema. c. Interview with the DON on 12/4/19 at 4:42 PM revealed the care plan lacked interventions to reduce edema.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		1/19/20

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F 690	Continued From page 15 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure appropriate catheter care was provided to prevent urinary tract infections for 1 of 3 sample residents (#20) with an indwelling catheter. The findings were: 1. Review of the quarterly MDS assessment dated 8/27/19 showed resident #20 had diagnoses which included obstructed uropathy and paraplegia. Further review showed the resident had an indwelling catheter and required extensive assistance of 2 or more people for bed mobility, dressing, and personal hygiene, and total assistance of 2 or more people for transfers and toilet use. The following concerns were identified: a. Observation on 12/4/19 at 12:03 PM showed CNA #1 and the resident entered the resident's room and the CNA positioned the mechanical lift above the resident. The CNA attached the mechanical lift sling to the lift and secured the catheter drainage bag to the sling between the resident's legs. CNA #2 entered the resident's room and CNA #1 lifted the resident with the mechanical lift. As the the resident was lifted out the wheelchair, the resident laid back-supine (lying face upward) and the drainage bag lifted above the resident's bladder. Visible urine in the catheter tubing flowed backward toward the resident's bladder. b. Review of the resident's care plan for	F 690	Correction for cited residents: Resident #20 1. Unable to correct for timeframe observed on 12/4/19 at 12:03 pm. Identification of other residents: The facility will review all residents with indwelling catheter in the last 30 days for appropriate catheter care to prevent urinary tract infection. Systematic changes and Monitoring: Education provided to staff by 1/19/20 regarding catheter care. Review and revisions of policy, Urinary Catheter Care. Outcome: All residents with an indwelling urinary catheter will have the catheter bag below the level of the bladder at all times. Any discrepancy noted during observation will be corrected immediately. A monthly audit will be completed related to catheter bag positioning with a sample size of 5 care observations per resident with indwelling catheter. 100% of residents identified in the monthly audit will have observed urinary catheter bag below the level of the bladder at all times. This data will be collected by Director of Nursing (or designee). Results will be aggregated	

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F 690	Continued From page 16 indwelling catheter last revised on 10/24/19 showed interventions which included "...Position catheter bag and tubing below the level of the bladder..." c. Interview with CNAs #1 and #2 on 12/4/19 at 12:26 PM revealed they had received training on cleaning catheters and they had been trained to hang the catheter drainage bag on the sling during transfers. d. Interview with the DON on 12/5/19 at 10:10 AM revealed a catheter drainage bag was not to be lifted above a resident's bladder as it increased the risk for infection and was uncomfortable for the resident. e. Review of the policy titled "Urinary Catheter Care" last updated on 2/2017 showed "...3. The drainage bag must be held/positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the the bladder..."	F 690	and reported at long term care quality meetings. All discrepancies will be investigated, corrected and reported.	
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;	F 692		1/19/20

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F 692	Continued From page 17 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure a nutritional assessment was completed to address weight concerns for 2 of 4 residents (#62, #134) identified with significant weight loss. The findings were: 1. Review of the 10/4/19 quarterly MDS assessment showed resident #62 had diagnoses which included delirium due to known psychological condition, vascular dementia without behavioral disturbance, adjustment disorder with depressed mood, iron deficiency anemia, gastro-esophogeal reflux disease, type 2 diabetes mellitus without complications, and long term use of antibiotics. Further review showed the resident was coded for significant weight loss and significant weight gain. Review of the 7/4/19 quarterly MDS assessment showed the resident had been coded for no weight loss and no weight gain. The following concerns were identified: a. Review of the resident's weights showed the resident had a 3% weight gain in 30 days (9/4/19 to 10/2/19) prior to the 10/4/19 quarterly MDS assessment, 0.49% weight gain in 90 days (8/7/19 to 10/2/19) prior to the assessment, and an 11.08% weight loss in 120 days (4/3/19 to 10/2/19) prior to the assessment. Further review showed the resident had an 8.63% weight loss in 30 days (5/22/19 to 6/26/19) prior to the 7/4/19	F 692	Correction for cited residents: Resident #62 1. Completion of a nutritional assessment and care plan update. 2. MDS correction was completed on 12/20/19. 3. Verification of scale calibration for all facility scales. Normally done every six months per facility procedure, last calibration was completed November 2019. Resident #134 1. Completion of a nutritional assessment and care plan update. 2. Verification of scale calibration for all facility scales. Normally done every six months per facility procedure, last calibration was completed November 2019. Identification of other residents: The facility will review all residents who have a documented weight loss within the last 30 days to verify a dietitian, assessment, individualized care plan and interventions are present in medical record. Systematic changes and monitoring: Education provided to staff by 1/19/20 regarding nutrition/hydration status	

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F 692	Continued From page 18 quarterly MDS assessment. b. Review of an "OPC meeting" note dated 10/22/2019 and timed 9:30 AM showed "...Resident has cut down on eating, Weight since July has been stable..." c. Interview with the nutrition services manager, director of nutrition services, and the registered dietitian on 12/4/19 at 5:02 PM revealed the dietitian would assess if a resident triggered for weight loss and they were not aware that the resident had triggered for weight loss. Further interview revealed they believed the weight loss was due to inaccuracies in scales used to weigh the resident and the resident had moved from one unit to another. d. Interview with the MDS coordinator on 12/5/19 at 9:33 AM revealed after she reviewed the documented weights, she felt the weight loss should have been coded on the 7/4/19 quarterly MDS and and she was unsure why both weight loss and weight gain was coded on the 10/4/19 quarterly MDS assessment. e. Interview with nutrition technician on 12/5/19 at 9:52 AM revealed the resident was coded as a weight gain, on the 10/4/19 quarterly MDS assessment, in error. Further interview revealed she believed the weight loss was the result of inaccuracies with the scale on two different units where the resident was weighed; however, the facility had not compared the scale measurements to identify the potential discrepancies. 2. Review of the 11/13/19 admissions MDS assessment showed resident #134 was admitted on 11/06/19 with diagnoses which included dementia with Lewy bodies, Parkinson's disease, type 2 diabetes mellitus, atherosclerotic heart disease of native coronary artery without angina	F 692	maintenance and weight procedure. Review and revise electronic review/ordering process for registered dietician within electronic health system. Review and revisions of policy, Weight Monitoring. Review and revisions of policy, Minimum Data Set (MDS) 3.0. Review of PCC report for weight monitoring Outcome: All residents with documented weight loss in last 30 days will have dietitian assessment, individualized care plan and interventions present in medical record. Any discrepancies will be corrected immediately. A monthly audit of all residents with documented weight loss will be completed to monitor the systemic changes. 100% of residents identified in the monthly audit will have a registered dietician assessment and individualized care plan and interventions. Data will be collected by Nutrition Director (or designee). Results will be aggregated and reported at long term care quality meetings. All discrepancies will be investigated, corrected and reported.	

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F 692	Continued From page 19 pectoris, insomnia, vitamin D deficiency, hypothyroidism, paroxysmal atrial fibrillations, and abnormal weight loss. Further review showed the resident had a BIMS (brief interview for mental status) score of 99 indicating severe impairment of cognitive skills for daily decision making. The following concerns were identified: a. Review of the resident's weights showed 168.2 pounds on 11/6/19 at 4:45 PM, 168.6 pounds on 11/7/19 at 8:28 AM, 167.0 pounds on 11/13/19 at 5:52 PM, 154.8 pounds on 11/27/19 at 2:35 PM, and 151.2 pounds on 12/4/19 at 12:55 PM. Further review showed a calculated weight loss of 10.11% over 28 days (11/6/19 to 12/4/19). All weights were shown to have been recorded using the standing scale. b. Interview with nutrition supervisor #1, the director of nutrition services, and the registered dietitian on 12/4/19 at 5:02 PM revealed the dietitian would complete an assessment if a resident triggered for weight loss and they were not aware that the resident had triggered for weight loss. 3. Review of the policy titled "Weight Monitoring" last revised 11/19 showed "...2. Staff will follow a consistent approach to weighing and use an appropriately calibrated and functioning scale (e.g. wheelchair or standing scale). Since weight varies throughout the day, a consistent process and technique (e.g. weighing the individual wearing a similar type of clothing, at approximately the same time of the day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, and verifying scale accuracy)	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		1/19/20

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F 698	Continued From page 20 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 by: Based on medical record review, staff interview, and review of standards of care, the facility failed to monitor residents after receiving dialysis for 2 of 2 residents (#59, #131) reviewed for dialysis care. The findings were: 1. Review of the quarterly MDS assessment dated 10/2/19 showed resident #59 was admitted on 8/2/19 with diagnoses which included diabetes, hypertension, and end stage renal disease (ESRD). Review of the care plan showed the resident received dialysis 3 times a week at a dialysis facility and interventions included to monitor/document/report as needed for signs and symptoms of renal insufficiency, which included changes in heart and lung sounds, and to monitor/document/report as needed for bleeding, hemorrhage, and bacteremia. Review of the medical record failed to show documentation related to post dialysis monitoring. 2. Review of the quarterly MDS assessment dated 11/8/19 showed resident #131 was admitted on 9/9/14 with diagnoses which included hypertension, heart failure, peripheral vascular disease, diabetes mellitus and ESRD. Review of the care plan showed the resident received dialysis 3 times a week at a dialysis facility. Interventions included to monitor/document/report as needed signs and symptoms of infection to access site, signs and symptoms of renal	F 698	Correction for cited residents: Resident #59 1. Unable to correct for timeframe leading up to 12/12/19. Education provided via email and in person by 12/16/19 on how to use appropriate, already established assessment tool. Validation of education to be completed by 1/19/20. Residents were assessed on 12/12/19. Resident #131 1. Unable to correct for timeframe leading up to 12/12/19. Education provided via email and in person by 12/16/19 on how to use appropriate, already established assessment tool. Validation of education to be completed by 1/19/20. Residents were assessed on 12/12/19. Identification of other residents: The facility will review all residents who require dialysis services in the last 30 days to ensure they receive dialysis services consistent with professional standards of practice including a pre and post dialysis assessment documented in the medical record. Systematic changes and Monitoring: Education provided to staff by 1/19/20 regarding dialysis care provided to residents.	

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F 698	Continued From page 21 insufficiency which included changes in heart and lung sounds, and new/worsening peripheral edema. Review of the medical record failed to show documentation related to post dialysis monitoring. 3. Interview with the DON on 12/4/19 at 4:53 PM revealed the facility had transitioned to a different electronic medical record system and the expectation was for staff to fill out the "COM-Pre/Post dialysis evaluation" form; however the form had not been filled out. She confirmed staff were not obtaining post dialysis vital signs, nor assessing the residents after returning from the dialysis center. Further interview revealed the facility did not have policies or protocols related to dialysis care. 4. According to Clinical Nursing Skills, Seventh Edition, 2008, pg. 804, ongoing care of the hemodialysis client includes "...check blood pressure and temperature, auscultate heart and lung sounds for signs of fluid overload, observe mental statues, weigh daily..."	F 698	Review and revision of policy, Dialysis Assessment. Outcome: All dialysis residents will be audited monthly for compliance related to pre/post assessment consistent with professional standards of practice. This data will be collected by Director of Nursing (or designee). Results will be aggregated and reported at long term care quality meetings. All discrepancies will be investigated, corrected and reported.	
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	F 758		1/19/20

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 22 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure appropriate	F 758	Correction for cited residents: Resident #102:	

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	535022	A. BUILDING _____ B. WING _____	12/05/2019

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F 758	Continued From page 23 psychotropic medication use for 1 of 5 sample residents (#102) identified for a medication regimen review. The findings were: 1. Review of the "Medication Review Report" for December 2019 showed resident #102 received Trazadone (antidepressant) 50 mg 1 tablet orally three times a day for anxiety and risperidone (antipsychotic) 0.25 mg 1 tablet orally two times a day for dementia with behaviors. The following concerns were identified: a. Review of a "Behavioral Health Committee & Provider Assessment" dated 11/1/19 showed "...2. Please indicate which behaviors are being controlled by the antipsychotic, how the resident is a danger to self and/or others, AND, what interventions have been tried and are ineffective, OR, what symptoms are identified as being due to mania or psychosis..." The physician responded "No change in medication. 1. Psychological distress from perceived pain already under treatment with narcotics. 2. Spontaneous wandering with fall risk..." b. Review of the "Behavior Management" care plan last revised on 11/19/19 showed the resident had obsessive behavior with pain/suspected urinary tract infections. Further review showed there were no identified target symptoms for each psychotropic medication the resident received. 2. Interview with the DON on 12/4/19 at 4:39 PM revealed the facility did not have specific target behaviors identified for individual medications and all behaviors were reviewed to determine if the medications remained appropriate.	F 758	1. Provider review of medications and justification of use. 2. Revision of care plan to address target behaviors associated with medication use. Identification of other residents: The facility will audit and review all residents who receive psychotropic medications in the last 30 days for necessity to treat a specific condition to include target behaviors on care plan and indication for medication use. Systematic changes and Monitoring: Education provided to staff by 1/19/20 regarding target behaviors related to psychotropic medication use. Education provided to provider team by 1/19/20 regarding target behaviors while ordering psychotropic medications. Review and revisions of policy, Psychoactive Medication Use and Monitoring. Revision of electronic documentation tool to collect target behavior information. Outcome: All residents utilizing psychotropic medications within the last 30 days will have a target behavior on their person centered care plan and an indication for use in the medical record. Any deficiencies will be corrected immediately. A monthly audit of 15 (10%), or 100% if less than 15 residents utilizing psychotropic medications, will be completed, to ensure target behavior and indication for use is in the medical record, to monitor the systemic changes. 100% of	

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F 758	Continued From page 24	F 758	residents identified in the monthly audit will have documented target behaviors that are aligned with the care plan and indication for psychotropic medication use. This data will be collected by Director of Nursing (or designee). Results will be aggregated and reported at long term care quality meetings. All discrepancies will be investigated and reported.	
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 staff interview, medical record review, and review of policy and procedure, the facility failed to establish an antibiotic stewardship program to monitor antibiotic use for 2 of 4 sample residents (#21, #126) with long-term antibiotic therapy. The findings were: 1. Review of the physician orders for resident #21 for December 2019 showed an order dated 11/26/19 for doxycycline hyclate (an antibiotic) 100 mg 1 tablet by mouth two times daily give indefinitely. Further review showed there was no stop date or time frame for assessment of continued use, and no rationale for long term use	F 881	Correction for cited residents: Resident #21: 1. Provider review of medications and rationale for long term use of antibiotic. 2. Revision of care plan to address use of antibiotic. Resident #126: 1. Provider review of medications and rationale for long term use of antibiotic. 2. Revision of care plan to address use of antibiotic. Identification of other residents: The facility will review all residents who	1/19/20

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F 881	Continued From page 25 of antibiotic. 2. Review of the physician orders for resident #126 for December 2019 showed an order dated 11/22/19 for doxycycline hyclate 100 mg 1 tablet by mouth two times daily for infection of left toes to be used indefinitely for arterial ulceration on toes. Further review showed there was no stop date or time frame for assessment of continued use, and no rationale for long term use of antibiotic. 3. Interview with the DON and infection preventionist on 12/5/19 at 10:10 AM confirmed the antibiotic stewardship committee had not reviewed the antibiotic use for resident #21 or resident #126. 4. Review of the policy titled "Antibiotic Stewardship Plan/Protocol" initiated 9/17 showed "...The scope of antibiotic stewardship program is to provide appropriate antibiotic use to protect resident and to prevent antibiotic resistance..."	F 881	have had antibiotic use within the last 30 days for adherence to the antibiotic stewardship program in place including antibiotics that are ordered will have a stop date, time frame for assessment of continued use or rationale documented for continued long term usage. Systematic changes and Monitoring: Education provided to staff by 1/19/20 regarding long term use of antibiotics. Education provided to antibiotic stewardship committee by 1/19/20 regarding survey findings. Education provided to provider team by 1/19/20 regarding rationale for long term use of antibiotics needed at time of ordering. Review and revisions of policy, Antibiotic Stewardship Plan. Outcome: 100% of residents who utilized antibiotics in the last 30 days will have indication for use, stop date or documented rationale for continued usage in the medical record. A monthly audit of all residents on antibiotics will be completed to monitor the systemic changes and adherence to the antibiotic stewardship program. 100% of residents identified in the monthly audit will have a stop date or time frame for assessment of continued use, and/or a rationale for long term use of antibiotic. This data will be collected by Director of Nursing (or designee). Results will be aggregated and reported monthly at long term care quality meetings. All discrepancies will be	

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F 881	Continued From page 26	F 881	investigated,corrected and reported.	