STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A002	A. BUILDING _____ B. WING _____	02/25/2021

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

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F 000	INITIAL COMMENTS A recertification survey which included a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys from 2/22/21 through 2/25/21. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing MAC: Medication Aide Certified MDS: Minimum Data Set RN: Registered Nurse 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, medical record review, staff and resident interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that MDS assessment information was an accurate reflection of resident status for 1 of 12 sample residents (#11). The findings were: 1. Review of the 12/14/20 quarterly MDS assessment showed resident #11 was admitted to the facility on 4/13/17 and wandered 4 to 6 times during the 7-day look-back period. The following	F 641	The facility will ensure that assessments accurately reflect the resident's status by: A)A modification/correction MDS for Quarterly MDS 12/14/20 was completed and transmitted for resident #11. On 3/12/21 a Quarterly MDS was completed for resident #11. It was coded correctly as resident having no wandering behavior. B) Nurse Team Leaders and MDS coordinator will audit all residents' most recent MDS's, ensuring wandering	4/11/21

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

Electronically Signed | 03/21/2021

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F 641	Continued From page 1 concerns were identified: a. Observation starting at 2/23/21 at 9:10 AM showed the resident propelled his/her wheelchair either to the dining room or to the common area of the facility. b. Review of the progress notes from 11/1/20 through 12/31/20 showed no wandering was documented during that time period. c. Review of care plan showed wandering had not been addressed. d. Interview with MAC #1 on 2/24/21 at 9 AM revealed wandering had never been a concern for the resident. Further, the resident was confined to a wheelchair due to weakness, and never traveled more than from the resident's room to the dining room or to activities. e. Interview with the resident on 2/22/21 at 5:11 PM revealed s/he had not been able to walk for several years, was wheelchair bound, and relied on the staff for assistance. 2. Interview with the resident assessment coordinator on 2/24/21 at 2:21 PM revealed she had always coded the resident for wandering, however was unsure as to where the information came from. 3. According to the MDS RAI Manual version 1.71.1 page 201 " E0900...Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to his or her physical or safety needs. The resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused	F 641	behavior is coded correctly. All facility staff involved in the MDS process will be educated that all residents have the potential to be affected by inaccurate coding of the MDS by April 11, 2021. C)The MDS IDT team will discuss resident's behaviors during the ARD period and agree on behaviors prior to completing section E. D)A PI tool will be developed by MDS coordinator to ensure accuracy of MDS coding. This will be completed monthly by MDS coordinator or designee and reported quarterly to the Performance Improvement Committee.	

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F 641	Continued From page 2 thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff know is deceased)...Traveling via a planned course to another specific place (such as going to the dining room to eat a meal or to an activity) is not considered wandering."	F 641		
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. §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	F 755		4/11/21

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F 755	Continued From page 3 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 available for use were not expired in 1 of 1 medication storage areas. The findings were: 1. Observation of the medication storage area on 2/24/21 at 10:41 AM showed approximately one half of a box of bisacodyl 10 milligram suppositories stored in the refrigerator had an expiration date of 1/2020. Interview with RN #1 at that time revealed she was unsure whose responsibility it was to check for outdated medication. Further, she stated outdated medication should not have been accessible for resident use. 2. Interview with the DON on 2/24/21 at 11:10 AM confirmed the outdated medications should have been removed from the medication storage room.	F 755	The facility will ensure medications available for use are not expired. A)The half box of Bisacodyl 10mg suppositories with an expiration date of 1/2020 was disposed of. B)All residents have the potential to be affected by outdated medications. A night nurse will check dates of all medications on the medication room monthly, noting anything with an expiration date that will expire within the next two months, on a Medication Expiration Form. This form will be posted in the medication room for ease of reference. C)DON will provide education to all nurses and medication aides on the need to check that medications are not outdated and on referencing the Medication Expiration form to ensure medications are disposed of before expiring. D)DON will develop a performance improvement tool to ensure outdated medications are removed from the medication room prior to expiration. DON will complete this PI tool monthly and the QAPI committee will review quarterly.	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757		4/11/21

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F 757	Continued From page 4 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications for 3 of 6 residents reviewed (#15, #20, #35) for medications. The findings were: 1. Review of the medical record for resident #15 showed the resident was admitted to the facility on 12/1/20 with a physician order for Macrobid (an antibiotic) 100 milligrams (mg) daily for UTI (urinary tract infection) prevention with no end date. Further review showed no evidence the resident's physician had provided justification for the continued use of the antibiotic. 2. Review of the medical record for resident #20	F 757	The facility will ensure that all resident's drug regiments are free from unnecessary drugs. A)The physician of each resident that is on a prophylactic antibiotic have been contacted and requested to provide appropriate documentation on use of prophylactic antibiotic. a) Resident #15: Physician had an appointment with resident and proper documentation of need for antibiotic was made in Resident's chart. b) Resident #20: Antibiotic was discontinued. c) Resident #35: A request for	

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F 757	Continued From page 5 showed the resident was admitted to the facility on 12/17/20 with a physician order for Macrobid 100 mg daily for chronic UTI with no end date. Further review showed no evidence the resident's physician had provided justification for the continued use of the antibiotic. 3. Review of the medical record for resident #35 showed the resident was admitted to the facility on 2/6/17. Review of the physician orders showed Macrobid 100 mg daily for UTI prophylaxsis was prescribed on 9/30/18 with no end date. Further review showed no evidence the resident's physician had provided justification for the continued use of the antibiotic. 4. Interview with the facility's pharmacist on 2/25/21 at 9:37 AM revealed she had recently addressed resident #35's use of the prophylatic antibiotic with the physician and had recommended the medication be discontinued due to the antibiotic being ineffective. Further, she stated resident #15 and resident #20 were new admissions to the facility and she liked to let them "settle in" before adjusting their medications.	F 757	antibiotic discontinuation has been made to the physician twice with no reply. Pharmacy and Director of Resident Care will continue to request discontinuation or appropriate documentation. B)Pharmacist will audit all residents' medications, ensuring physician's documentation justification for any antibiotics. Upon admission, the pharmacist and physician will review all medications and remove any unnecessary drugs. C)During monthly medication reviews, the pharmacist will continue to monitor for unnecessary drugs. D)Pharmacy will develop a performance improvement tool to ensure and document that each resident is having their medications reviewed for unnecessary medications. Pharmacist will complete monthly and report to QAPI quarterly.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/11/21

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F 812	Continued From page 6 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, product label review, and review of the 2017 food code, the facility failed to ensure food was properly stored and distributed under sanitary conditions in 2 of 2 food storage areas observed (main kitchen, first floor resident pantry) and failed to ensure outdated dairy products were not served to residents during 1 random observation which involved resident #12. The findings were: 1. Observation of the resident refrigerator labeled "Pantry" on 2/22/21 at 3:55 PM showed a quart-sized container of Dairy Pure half and half with a use by date of 2/17/21, a thickened dairy drink with a use by date of 1/6/21, and a peach nectar drink dated 10/13/20 with a label which stated "...refrigerate after opening and consume within 3 days". The refrigerator had a dried brown substance on the top shelf that had dripped down to the second through fifth shelves. In addition to the brown substance the bottom of the refrigerator also had dried orange debris adhered to the surface and the side storage compartments were discolored. 2. Observation on 2/24/21 at 10 AM of the same "Pantry" refrigerator showed the thickened dairy	F 812	The facility will ensure food is properly stored and distributed under sanitary conditions and that out dated products are not served to resident. A)All outdated food in pantry refrigerator has been discarded and the refrigerator has been thoroughly cleaned. Resident#12 receives half and half that is not outdated. All outdated food in Gibson freezer was disposed of. B)All resident have the potential to be affected by food that is outdated or kept in unsanitary conditions. RD updated Refrigerator Protocol, directing when certain foods must be discarded. This is posted on the front of the refrigerator. Night shift CNAs will check refrigerator every night, cleaning it and ensuring outdated items are disposed of. These checks will be documented on a form developed by the DON.	

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F 812	Continued From page 7 drink had been discarded, the Dairy Pure half and half with a use by date of 2/17/21 had been replaced with a carton that had a use by date of 2/21/21, and the peach nectar drink remained. The brown and orange substances in the refrigerator had been cleaned, however some orange stains were still visible behind the bottom storage unit, and the side storage compartments remained discolored. 3. Observation on 2/22/21 at 3:55 PM of the Gibson heavy duty freezer found in the main kitchen showed: a. One plastic storage bag dated 5/15/20 was labeled "pancake for puree" and showed visible frost build-up in the bag. b. One plastic storage bag dated 6/6/20 was labeled "french toast for puree" and showed visible frost build-up in the bag. c. One plastic storage bag dated 8/15/19 was labeled "gluten free wild blueberry muffins" and showed visible frost build-up in the bag. d. One plastic storage bag dated 7/20/20 was labeled "gluten free muffins" and showed visible frost build-up in the bag. e. A loaf of soft white bread in the original packaging had a date of 9/5/20 and showed visible frost build-up in the bag. f. A plastic storage bag dated 11/19/19 was labeled "gluten free rolls" and showed visible frost build-up in the bag. g. One plastic storage bag dated 2/16/20 was labeled "birthday cake" and showed visible frost build-up in the bag. h. One box of Vans gluten free blueberry waffles had a use by date of 2/20/21. i. One box of Vans gluten free original waffles had a use by date of 1/6/21.	F 812	Cooks will check the Gibson freezer daily, ensuring outdated items are disposed of. DM will add this task to the cooks' chore list. At least weekly, pantry refrigerator and Gibson freezer will be randomly checked by DON, DM or RD to ensure cleanliness is maintained, items are labeled appropriately, and outdated items are disposed of. Immediately inservicing will be provided as needed. C) DON or designee will educate AHCC nurses, CNAs and Activities staff o the updated Refrigerator Protocol, the need to ensure the pantry refrigerator is kept clean, how to label items appropriately, and ensure that outdated items are discarded. DM will educate dietary staff on the process of proper labeling and dating of products including discard dates and storage guidelines. D)DON will develop a performance improvement tool to ensure the pantry refrigerator is clean and outdated items are discarded. DON will complete monthly and the QAPI Committee will review quarterly. DM will develop a performance improvement tool to ensure that outdated food in the Gibson freezer is disposed of. DM will complete monthly and the QAPI Committee will review quarterly.	

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F 812	Continued From page 8	F 812		

4. Observation on 2/24/21 at 4:30 PM showed a quart-sized carton of half and half with a use by date of 2/21/21 was on the cold storage area of the service line in preparation for the evening meal. At 5:01 PM a CNA was observed pouring some of the half and half into a mug of coffee and then served the beverage to resident #12.

5. Interview with cook #1 on 2/24/21 at 4:39 PM revealed the "Pantry" refrigerator/freezer had snacks, juice, and ice cream available to the residents after the kitchen closed in the evening.

6. Interview and observation of the "Pantry" refrigerator with the dietary manager on 2/25/21 at 10:34 AM revealed it was the night CNA's responsibility to clean and discard the outdated food in the "Pantry" refrigerator. In addition, she stated the Gibson freezer was used to store gluten-free products for a resident that no longer resided at the facility. The dietary manager discarded the outdated food from the "Pantry" refrigerator and the half and half from the cold storage area of the service line at that time.

7. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."