STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/29/21 to 4/1/21. Also reviewed in the course of the survey was complaint intake WY00003201. The following common abbreviations are used throughout this document: DON- Director of Nursing CNA- Certified Nursing Assistant MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 606		5/4/21

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

Electronically Signed | 04/24/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 606	Continued From page 1 §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure a CNA registry check was performed for 2 of 3 CNAs (#1, #2) prior to resident contact. The findings were: 1. Review of the employee file for CNA #1 showed the CNA had a hire date of 1/16/20 and there was no evidence an abuse registry check was performed. 2. Review of the employee file for CNA #2 showed the CNA had a hire date of 1/16/20 and there was no evidence an abuse registry check was performed. 3. Interview with the business office manager on 4/1/21 at 10:27 AM revealed the facility checked the abuse registry at the time of hire; however, they did not print a verification for the employee file. Further interview revealed a printed verification should be in each CNA's employee file.	F 606	This plan of correction is the centers credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. 1. Corrective Action:SDC immediately resubmitted the abuse/registry for CNA staff currently employed. SDC resubmitted CNA abuse registry for CNA #1 and #2. Submitted abuse/registry for CNA #3 and #4 have temporary license forms submitted although they cannot be placed on registry until obtaining a permanent license. Copies of the abuse/registry were placed in the employee files. 2. ID of others:Initial audit completed of employee files on 4/2/21 to assess for further concerns related to missing documentation. 3. Systemic Change: SDC or designated staff member will conduct orientation to ensure abuse registry paperwork is completed upon hire for a new CNA. Business Office Manager re-educated on	

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F 606	Continued From page 2	F 606	4/2/21 to ensure appropriate documentation is included in employee files. 4.Monitoring: Weekly audits of new hires for CNA abuse registry will be completed by SDC or designee weekly x 4 weeks, then monthly x2. Results of initial and ongoing audits will be reviewed via monthly QAPI for further recommendations.	
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 medical record review, staff interview, review of the resident assessment instrument (RAI)3.0 manual, and policy and procedure review, the facility failed to ensure MDS assessments were accurately completed for 1 of 19 sample residents (#18). The findings were: 1. Review of the 7/26/20 admission MDS assessment for resident #18 showed the resident admitted to the facility on 7/21/20 with diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, and anxiety disorder. Further review showed the resident's weight at the time of admission was 146 pounds (lbs). a. Review of quarterly MDS assessment dated 11/24/20 showed the resident's weight was 129 lbs, an 11.64% weight loss since the admission assessment. Further review showed the resident was marked as "no or unknown" for section K300, Loss of 5% or more in the last	F 641	1. Corrective Action: MDS from 11/24/20 modification completed and accepted on resident # 18. 2. ID of others:Initial audit completed by MDS Coordinator/Designee on 4/23/21 to assess for other concerns related to MDS accuracy regarding weight loss. 3. Systemic Change: Education provided to IDT by DNS/Designee on 4/2/21 related to accuracy of MDS information. Prior to submitting the assessment MDS Coordinator/Designee will review weights for weight loss to ensure correct coding on assessment. 4. Monitoring: Audit will be completed by MDS/Designee weekly x 4 of section K of MDS being submitted, then monthly x 2. Results of initial and ongoing audits will be reviewed via the monthly QAPI meeting for further recommendations.	5/4/21

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F 641	Continued From page 3 month or loss of 10% or more in last 6 months. b. Review of the resident's weight record showed the resident weighed 145.8 lbs on 7/21/20 and 124.8 lbs on 11/23/20 (14.4% loss). c. Interview with the MDS coordinator on 4/01/21 at 9:42 AM confirmed the resident did have a weight loss greater than 10% at the time of the 11/24/20 MDS assessment and revealed the assessment should have been coded as a weight loss. d. Review of the "Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual Version 1.17.1" last revised October 2019 showed "...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. 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..." e. Review of the policy titled "Weights" last updated November 2012 showed "...b. Weekly Weights...Significant weight Loss/gain. 5% 30 days...7.5% 90 days...10% 180 days..."	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		5/4/21

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F 645	Continued From page 4 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 645		

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F 645	Continued From page 5 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) Level II was performed for 1 of 2 sample residents (#37) with a qualifying diagnosis. The findings were: 1. Review of the medical record for resident #37 showed the resident had a readmission date of 2/7/2018. Further review showed the resident had diagnoses which included delusional disorders with an onset date of 4/30/2018. The following concerns were identified: a. Review of the PASARR Level I completed on 2/4/2021 showed diagnoses of delusional	F 645	1. Corrective Action:Education was provided by ED on 4/22/21 to social service director, admissions coordinator and business office manager the requirements regarding PASARR IIs and category 6s prior to admission. PASARR level two to be completed on resident # 37 as soon as possible and before the date of compliance. 2. ID of Others:Initial audit completed by DNS/Designee on 4/24/21 of PASARR screenings for appropriate levels of PASARR with corrections as needed. 3. Systemic Change:Education was provided by ED on 4/22/21 to social	

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F 645	Continued From page 6 disorders and dementia in other diseases classified elsewhere with behavior disturbance. Further review showed the resident was marked "yes" for two of three questions related to mental illness screening, all triggering the need for completion of a PASARR Level II. Review of the medical record showed no evidence a PASARR Level II was performed. b. Interview with the admissions coordinator and facility administrator on 4/1/21 at 9:55 AM confirmed the qualifying diagnoses required completion of the PASARR Level II. Further interview confirmed no PASARR level II was initiated or completed.	F 645	service director, admissions coordinator and business office manager on the requirements regarding PASARR IIs and category 6s prior to admission. All potential admissions will be screened prior to admission for need of PASARR level two. PASARR will be completed prior to admission. Upon obtaining a new MD & ID diagnosis a PASARR level one will be completed to evaluate the need for a PASARR level II. 4. Monitoring: Audits to be completed by Admission Coordinator/Designee of new admissions and for new medical diagnosis for current residents to be completed weekly x 4, monthly x 2. Results of initial and ongoing audits will be reviewed via the monthly QAPI meeting for further recommendations.	
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	F 692		5/4/21

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F 692	Continued From page 7 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, resident representative and staff interview, and policy and procedure review, the facility failed to ensure nutritional status was maintained for 1 of 2 sample residents (#18) reviewed for weight loss. The findings were: 1. Review of the admission MDS assessment dated 7/26/20 showed resident #18 admitted to the facility on 7/21/20 with diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, and anxiety disorder. Further review showed the resident's weight at the time of admission was 146 pounds (lbs). Review of the "Nutrition Hydration Cognitive Issues" care plan last revised on 8/4/20 showed the resident had interventions which included "...supplement per MD Order...Educate Resident on Diet Principles...Encourage to eat 50 percent or more of meals...If Intake 50 percent or less, offer substitute or supplement..." The following concerns were identified: a. Observation on 3/29/21 at 6:07 PM showed the resident was in bed leaning to his/her left side and a meal tray was positioned on the bedside table. The resident was not eating and did not receive staff assistance. The DON entered the resident's room at 6:16 PM and spoke to the resident and his/her roommate then left. An unidentified staff member entered the resident's room at 6:25 PM and assisted the resident to eat, 19 minutes after the tray was put	F 692	1. Corrective Action: Resident #18 was weighed immediately while surveyors in the building. Residents placed on weekly weights. Nutrition evaluation completed on 4/16/21 by RD. Continue NEM and calorie dense supplement as ordered. Weekly weights to be completed and follow trends with current care/interventions as her weight has recently been in a tight range. Current licensed nurses and CNAs educated on appropriate meal service assist 0n 4/1/21 and 4/22/21. 2.ID of others:Initial audit completed on 4/21/21 by DNS/Designee to assess for any other weight loss concerns. Audit completed on 4/21/21 by DNS/Designee to assess for appropriate meal assistance for those residents who require assist with meal service. 3.Systemic Change:Guidelines for residents who may need to be weighed weekly and for new admits will be followed per policy. Weekly weights will be assigned as tasks in the charting system. The nutrition hydration skin committee will meet weekly to review weights, refer residents to RD and MD as needed. On-going evaluations will be completed for review. Review/revise the care plan with measurable goals and appropriate interventions. Staff education provided by DNS/Designee for appropriate meal	

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F 692	Continued From page 8 in the room. b. Observation on 3/31/21 at 12:36 PM showed the resident was in the dining room, seated in his/her wheelchair, leaned over, and resting with his/her eyes closed. An unidentified staff member placed the resident's tray on the table near where the resident was positioned. At that time, the staff member cut the resident's food and attempted to wake the resident with verbal cues. An unidentified staff member returned to the resident's table at 12:41 PM and attempted to wake the resident with verbal cues, which was successful. The staff member left the table and the resident drank his/her milk and ate 3 bites of food. RN #1 attempted to provide verbal cues to the resident at 12:51 PM. No further assistance was attempted during the meal and staff did not offer the resident an alternative meal or meal supplement at that time. c. Interview with the resident's representative on 3/30/21 at 9:02 AM revealed the resident had lost weight and it was noticeable due to clothing which did not fit. Further interview revealed the family had to supply tighter fitting clothing and the representative thought the resident had lost "10 or 12 pounds" since admission. d. Review of the quarterly MDS assessment dated 11/24/20 showed the resident's weight was 129 lbs, an 11.64% weight loss since the admission assessment. Further review showed the resident was marked as "no or unknown" for section K300, Loss of 5% or more in the last month or loss of 10% or more in last 6 months. e. Review of the resident's weight record showed the resident weighed 145.8 lbs on 7/21/20, remained between 136 lbs and 132 lbs from 9/27/20 to10/24/20, weighed 124.8 lbs on 11/23/20 (14.4% loss since admission), weighed 132.4 lbs on 12/21/20, and weighed 125.8 lbs on	F 692	service assistance, obtaining weights timely, and to provide an alternative meal for those residents who consume 50% or less of their meal. 4. Monitoring: Audits of weights will be completed by DNS/Designee weekly x 4, monthly x 2, for residents that have flagged on weight loss. Audits will be completed by DNS/Designee weekly X 4 and monthly x 2 to assess for appropriate meal service assistance including the provision of alternate meals for those who consume less than 50% of meal. Results of initial and ongoing audits will be reviewed at the monthly QAPI meeting for further recommendations.	

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F 692	Continued From page 9 2/7/21. Review of a weight provided by a facility staff member on 3/31/21 at 7:31 PM showed the resident weighed 121.1 lbs (16.94% loss since admission). e. Interview with the DON on 4/1/21 at 10:03 AM revealed her expectation was for staff to offer alternative meals, offer snacks, and attempt to assist the resident per the resident's care plan. Further interview revealed the resident had an initial weight loss due to fluid retention and the implementation of a diuretic medication. f. Review of the policy titled "Weights" last updated November 2012 showed "...b. Weekly Weights...Significant weight Loss/gain. 5% 30 days...7.5% 90 days...10% 180 days..."	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure respiratory equipment was clean and in good repair for 1 of 1 sample residents (#195) who uses a continuous positive airway pressure (CPAP) machine. The findings were: 1. Observation on 3/29/21 at 2:02 PM showed resident #195 was in his/her room and a CPAP	F 695	1. Corrective Action: When DNS noted CPAP mask soiled the mask was immediately thrown away and replaced with a new mask for resident # 195, mask was dated upon change. Order written to monitor CPAP daily, if soiled clean machine parts with soap and water, replace parts as needed and remind residents not to use while eating.	5/4/21

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F 695	Continued From page 10 machine was positioned on the resident's dresser near the bed. The CPAP mask was visibly dirty with dark brown and black stains on the seal edge near the chin area and water spots on the mask frame. Further observation showed discoloration was present on the right side of the mask strap and the machine's display window had a build up on it which prevented seeing messages which were displayed. None of the equipment had dates to indicate when the equipment was cleaned, changed, or serviced. Observation on 3/30/21 at 11:54 AM showed the resident was laying in bed, with the CPAP mask on. The mask, mask strap, and machine remained visibly dirty. Observation on 3/31/21 at 9:17 AM showed RN #1 entered the resident's room and assisted the resident with the facemask. The resident's mask, mask strap, and machine remained visibly dirty and the nurse did not change or clean the equipment. 2. Review of the physician orders showed the resident did not have orders for equipment change or cleaning frequency. 3. Review of the baseline admission care plan showed the CPAP was identified on the baseline admission care plan; however, there no cleaning or equipment change information identified. 4. Review of a progress note dated 3/31/21 and timed 10:01 AM showed it was a late entry note for "3/19/21 at 9:58 AM" which stated "Resident in room today this nurse is in to inspect skin and noted that his CPAP mask and tubing in disrepair, dirty, Removed tubing and mask, cleaned the machine and replaced mask and tubing with new. Resident is thankful for this..."	F 695	2. ID of others: Initial audit completed by DNS/Designee on 4/21/21 to assess for other soiled respiratory equipment with corrections made as needed. 3. Systemic Change: Upon admission CPAP/Respiratory equipment order set to be placed on treatment record for nurse to monitor. Staff education provided and completed on 4/23/21 by DNS/Designee related to respiratory equipment cleaning/replacing when soiled. 4. Monitoring: Audits to be completed by IP/Designee weekly x 4, monthly x 2 and then as needed. Results of initial and ongoing audits will be reviewed via the monthly QAPI meeting for further recommendations.	

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RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 695	Continued From page 11 5. Interview with RN #1 on 3/31/21 at 9:38 AM revealed the nurses added distilled water to the machine and they did not perform any other tasks such as cleaning or changing equipment. 6. Interview with the DON on 3/31/21 at 9:39 AM revealed the resident's mask and tubing was changed "within the last month." The DON was unable to find supporting documentation of equipment change at that time. Further interview revealed the parts were to be cleaned when the staff observed they were dirty and the facility did not date the tubing or mask when changed. After observation of the mask, the DON confirmed it was dirty and the facility should change it.	F 695		
F 744 SS=E	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide appropriate treatment and services to residents diagnosed with dementia in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 2 of 4 sample residents (#21, #22). The findings were: 1. Review of the annual MDS assessment dated 2/9/21 showed resident #22 had diagnoses which included non-Alzheimer's dementia, psychotic disorder, anxiety disorder, and depression. Further review showed the staff assessment of	F 744	1. Corrective action: Resident # 22 behavior/mood monitoring flow sheet updated with target behaviors for each medication. Resident #22 care plan updated with target behaviors and specific non pharmacological interventions for behavior. Physician rationale placed in resident chart. Resident # 21 order written to monitor behavior q shifts. Resident # 21 care plan updated with target behaviors and specific non pharmacological interventions. 2. ID of others: Initial audit of those	5/4/21

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F 744	Continued From page 12 the resident's mood indicated the resident displayed behaviors of "feeling tired or having little energy" between 2 to 6 days during the look back period. Review of physician's orders showed the resident was ordered Lexapro 5 milligrams (mg)(antidepressant) by mouth once per day on 3/20/21, Ativan 0.5 mg (antianxiety) by mouth 3 times per day on 6/19/19, and Risperdal 0.25 mg (antipsychotic) by mouth once per day on 1/30/20. The following concerns were identified: a. Review of the medication administration record for January 2021, February 2021, and March 2021 showed an order to"Monitor behavior and document every day and night shift for monitoring q [every] shift and PRN [as needed]. Further review showed no specific target symptoms or non-pharmacological interventions were identified. b. Review of a "Behavior/Mood Monitoring flowsheet" dated January 21 showed target behaviors of delusions, possessive of communal dining, wandering, anxiety, and pressured speech. Further review showed no specific target symptoms or non-pharmacological interventions were identified. c. Review of a "Behavior/mood Monitoring Flowsheet" dated March 21 showed target behaviors of delusions, possessive of communal dining, wandering, anxiety, and pressured speech. Further review showed the resident had behaviors on 3 days which included pacing, delusions, and a shower refusal. Further review showed a non-pharmacological intervention was attempted once. d. Review of the "Resident Mood and Behavior Concerns" care plan last revised on 2/6/20 showed the resident had interventions which included "Allow Resident to voice concern(s)/express opinion(s)...Approach	F 744	residents on psychotropic medications to be completed on 4/28/21 by SSD/Designee to ensure behavior/mood monitoring flow sheets are in place and utilized, care plans are updated to include target behaviors and non-pharmacological interventions. 3. Systemic Change: Behavior/mood monitoring flow sheet will be updated with target behaviors for each medication and placed as charting tasks in the POC module for CNA to chart each shift. Care plans updated with target behaviors and specific non pharmacological interventions for behavior. Quarterly reviews of psychotropic use completed and GDR assessed per CMS guidelines. Education provided by DNS/Designee on 4/23/21 to IDT, nursing, and social services related to behavior/mood monitoring, target behaviors, specific non-pharmacological interventions, GDRs, and appropriate physician rationale related to GDRs. 4. Monitoring: Audit will be completed by SSD or designee on behavior/ mood monitoring weekly x 4 Monthly x 2. Audit of care plans for psychotropic medication, target behavior and non- pharmacological interventions weekly x 4, monthly x 2. Audit to ensure quarterly review of psychotropic medications used for assessment of GDR monthly x 3. Audit of order to monitor behavior q shift done weekly x 4. Results of initial and ongoing audits will be reviewed via the monthly QAPI meeting for further recommendations	

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Resident in a calm unhurried manner and speak in a calm voice...Assess [resident's name] for: Pain Issues, Hunger, Discomfort, Constipation...Encourage Resident to avoid napping during day, to stay awake to enable sleep at night...Establish a routine, encourage Resident to do as much as possible...Explain need for procedures and facility policy when necessary...Inform social services will meet with Resident to review and/or revise plan of care/treatment(s) if appropriate...Involve Resident and/or family member in mutual problem solving...Listen attentively/attempt to resolve concern(s)...Make sure all other residents are safe and out of harm's way...Medication(s) as ordered by MD with dose reduction(s) as MD warrants...Monitor behavior(s) Q shift/assess Q quarter...Monitor for any possible side effects...Remind Resident that rude or hurtful remarks are inappropriate...Verify the situation....The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] advancing of dementia...Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion...Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status...." Further review showed the care plan did not identify specific target symptoms or non-pharmacological interventions to treat specific target symptoms.

e. Review of the "impaired cognitive function/dementia or impaired thought processes r/t advancing of dementia" care plan last revised

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F 744	Continued From page 14	F 744		

on 1/13/18 showed interventions which included "I will maintain current level of cognitive function through the review date...The resident will maintain current level of cognitive function through the review date...Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion...Monitor/document/report PRN any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status..." Further review showed the care plan did not identify specific target symptoms or non-pharmacological intervention to treat specific target symptoms.

2. Review of the medical record showed resident #21 was admitted to the facility on 8/5/2020 with diagnoses which included adult failure to thrive, unspecified dementia without behavioral disturbance, and other specified mental disorders due to known physiological condition. The following concerns were identified:

a. Review of the resident's current physician orders showed the resident was taking the medication Seroquel (antipsychotic) two times per day for "other specified mental disorders due to known physiological condition," and Donepezil (cognitian-enhancing)once per day for "unspecified dementia without behavioral disturbance." Orders for monitoring side effects of the medications were in place; however, no orders for behavioral monitoring or non-pharmacological interventions related to specific target symptoms were identified.

b. Review of the resident's current care plan, last updated 8/24/2020, showed "interventions/tasks" related to dementia as

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F 744	Continued From page 15 "monitor behaviors every shift." The care plan showed "problems" listed as "the resident has a communication problem r/t dementia" and "the resident has a mood problem r/t Disease Process other specified mental disorders due to known physiological condition... is prescribed psychotropic medications to assist [him/her] and decrease mood problems." Interventions listed included monitoring and documentation tasks; however, the facility failed to identify specific target symptoms or non-pharmacological interventions. 3. Interview with the social services director and the DON on 3/31/21 at 5:04 PM revealed the facility did not identify the specific target symptoms or resident specific non-pharmacological interventions.	F 744		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		5/4/21

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F 758	Continued From page 16 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, staff interview, and policy and procedure review the facility failed to ensure unnecessary psychotropic medications were not used for 1 of 6 sample residents (#22). The findings were: 1. Review of the annual MDS assessment dated 2/9/21 showed resident #22 had diagnoses which	F 758	1. Corrective Action:Resident # 22 behavior/mood monitoring flow sheet updated with target behaviors for each medication. Resident #22 care plan updated with target behaviors and specific non-pharmacological interventions for behavior. Physician rationale placed in resident chart.	

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F 758	Continued From page 17 included non-Alzheimer's dementia, psychotic disorder, anxiety disorder, and depression. Further review showed the staff assessment of the resident's mood indicated the resident displayed behaviors of "feeling tired or having little energy" between 2 to 6 days during the look back period. Review of physician's orders showed the resident was ordered Lexapro (antidepressant) 5 milligrams (mg) by mouth once per day on 3/20/21, Ativan (anti-anxiety) 0.5 mg by mouth 3 times per day on 6/19/19, and Risperdal (antipsychotic) 0.25 mg by mouth once per day on 1/30/20. The following concerns were identified: a. Review of the medication administration record for January 2021, February 2021, and March 2021 showed an order to"Monitor behavior and document everyday and night shift for monitoring q [every] shift and PRN [as needed]. Further review showed no specific target behaviors were identified for each medication and no behaviors were documented. b. Review of a "Behavior/Mood Monitoring flowsheet" dated January 21 showed target behaviors of delusions, possessive of communal dining, wandering, anxiety, and pressured speech. Further review showed no behaviors were documented and the target behaviors were not identified for each medication the resident received. c. Review of the Resident Mood and Behavior concerns care plan last revised on 2/6/20 showed the resident had interventions which included "Allow Resident to voice concern(s)/express opinion(s)...Approach Resident in a calm unhurried manner and speak in a calm voice...Assess [resident's name] for: Pain Issues, Hunger, Discomfort, Constipation...Encourage Resident to avoid napping during day, to stay	F 758	2. ID of others:Initial audit of those residents on psychotropic medications to be completed on 4/28/21 by SSD/Designee to ensure residents are not receiving unnecessary psychotropic medications. 3.Systemic Change:Behavior/ mood monitoring flow sheet will be updated with target behaviors for each medication and placed as charting tasks in the POC module for CNA to chart each shift. Care plans updated with target behaviors and specific non pharmacological interventions for behavior. Quarterly reviews of psychotropic use completed and GDR assessed per CMS guidelines. Education provided by DNS/Designee on 4/23/21 To IDT, nursing, and social services related to behavior/mood monitoring, target behaviors, specific non-pharmacological interventions, GDRs, and appropriate physician rationale related to GDRs. 4. Monitoring: Audit will be completed by SSD/Designee on behavior/mood monitoring weekly x 4, and monthly x 2. Audit of care plans for psychotropic medication, target behavior and non-pharmacological interventions weekly x4, monthly x 2. Audit to ensure quarterly review of psychotropic medications used for assessment of GDR monthly x 3. Results of initial and ongoing audits will be reviewed via the monthly QAPI meeting for further recommendations	

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awake to enable sleep at night...Establish a routine, encourage Resident to do as much as possible...Explain need for procedures and facility policy when necessary...Inform social services will meet with Resident to review and/or revise plan of care/treatment(s) if appropriate...Involve Resident and/or family member in mutual problem solving...Listen attentively/attempt to resolve concern(s)...Make sure all other residents are safe and out of harm's way...Medication(s) as ordered by MD with dose reduction(s) as MD warrants...Monitor behavior(s) Q shift/assess Q quarter...Monitor for any possible side effects...Remind Resident that rude or hurtful remarks are inappropriate...Verify the situation....The resident has impaired cognitive function/dementia or impaired thought processes r/t advancing of dementia...Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion...Monitor/document/report PRN any changes in cognitive function, specifically
changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental
status...." Further review showed the care plan did not identify specific target symptoms or non-pharmacological interventions to treat specific target symptoms.

d. Review of a "Behavior/mood Monitoring Flowsheet" dated March 21 showed target behaviors of delusions, possessive of communal dining, wandering, anxiety, and pressured speech. Further review showed the resident had behaviors on 3 days which included pacing, delusions, and a shower refusals. Further review showed non-pharmacological interventions were

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attempted for one documented behavior. The specific target symptoms were not identified for each medication the resident received.

e. Review of a gradual dose reduction review dated 9/4/20 showed the medications for review were Risperdal and Ativan. The behaviors section showed "delusional disorder, can be verbally and physically aggressive, pressured speech, possessive of communal items, wandering, and high anxiety." Request for change of medication was crossed out and a hand written statement of "GDRs are contraindicated as they have been attempted in the past with adverse reaction. [S/he] is at [his/her] lowest therapeutic dose." The review was signed by the physician with a typed statement of "Recommendations reviewed, GDRs contraindicated at this time." There was no evidence the resident's behaviors were reviewed and no physician rationale was provided for continued use.

f. Interview with the social services director and the DON on 3/31/21 at 5:04 PM revealed they were aware of very specific target symptoms which included: the resident having delusions of being wet and becoming anxious related to delusions of being wet; however, it was confirmed the facility did not identify specific target symptoms for individual psychotropic medications on the care plan or behavior monitoring. Further interview revealed the facility did not have a way to identify the effectiveness of medications based on monitoring of specific target symptoms.

g. Review of the "Psychotropic Drugs" policy last updated January 2019 showed "5. Prior to initiating any psychotropic drug, the IDT: a. Reviews the medical record, PHQ9 and Brief Interview for Mental Status (BIMS) on Minimum Data set (MDS), Behavior Monitoring Flowsheet, progress notes, and evaluations related to

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F 758	Continued From page 20 behavior...c. Investigates causal factors triggering the behavior symptoms for residents exhibiting behaviors...7. Gradual Dose Reduction (GDR) Guidelines...e. a resident need not undergo a gradual dose reduction if:...ii. The resident's physician provides a justification why the continued us of the drug and dose are clinically appropriate..."	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.	F 801		5/10/21

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F 801	Continued From page 21 (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service	F 801		

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F 801	Continued From page 22 managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the facility staff list, and review of the facility job description, the facility failed to ensure a dietitian or qualified clinical nutrition professional was designated as the director of food and nutrition services. The census was 43. The findings were: 1. Interview with the dietary manager on 3/31/21 at 11:35 AM revealed she was not a certified dietary manager, the facility did not have a full time dietitian, and she had been employed by the facility for 3 months. Further interview revealed the dietary manager was enrolled in a training course. 2. Review of the staff list provided by the facility on 4/1/21 showed the dietary manager had a hire date of 12/1/20. 3. Interview with the administrator on 3/31/21 at 7:01 PM confirmed the dietitian was a full time employee with the company and not a full time employee at the facility. 4. Review of the "Food and Nutrition Services Manager" job description last updated November 2016 showed "...Education, Licensure, and Experience...1. Meets the qualifications for a Dietary Manager set by State and Federal regulations..."	F 801	F801 S/S F 1. Corrective Action: Dietary Manager is not licensed, but is currently working under the guidance and instructions of the facility□s licensed dietician. She has enrolled in the International Food Service Executives Association Certified Food Manager Course. 2. ID of others: Not applicable. There is only one dietary manager in the facility. 3. Systemic Change: Dietary Manager started the CDM program February 25, 2021 and is continuously taking assigned courses through the program to become licensed. She has also enrolled into the International Food Service Executives Association Certified Food Manager Course. 4. Monitoring: Will have dietician go from part time to full time employee with Rawlins Rehab and Wellness until Dietary Manager is able to obtain certification that she has completed the International Food Service Executives Association Certified Food Manager Course	