STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	**1990 WEST LOUCKS STREET SHERIDAN, WY 82801**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/13/21 to 9/16/21. The following common abbreviations are used throughout this document: DON: Director of Nursing RN: Registered Nurse LPN: Licensed Practical Nurse CNA: Certified Nursing Assistant MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		10/31/21

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

Electronically Signed | 10/08/2021

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F 609	Continued From page 1 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, review of State Survey Agency incident report logs, and policy and procedure review, the facility failed to report allegations of abuse to the State Survey Agency for 1 of 2 residents (#30) reviewed for abuse. The findings were: 1. Review of the admission MDS assessment dated 7/21/21 showed resident #30 had diagnoses which included hip fracture, other fracture, non-Alzheimer's dementia, and asthma. Further review showed the resident had a brief interview of mental status (BIMS) score of 6 out 15, which indicated the resident was severely cognitively impaired. The following concerns were identified: a. Interview with CNA #3 on 9/15/21 at 4:35 PM revealed the CNA had observed RN #1 attempting to give the resident medications on a camera monitor at the nurse's station. The resident attempted to refuse the medications and the CNA observed the RN kneel on the resident's arm and put the medications in the resident's mouth. The CNA and LPN #1 went to the resident's room after the observation on the camera monitor and upon entering the room, observed the resident spit out the medication.	F 609	Preparation and execution of this response and plan of correction does not constitute an 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 the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual 1. Resident #30 remains in the facility. Incident was reported through state portal. No other reportable occurrences have taken place and no negative outcomes have resulted in the incident not being reported. Staff member was terminated. 2. All residents involved in allegations of abuse or neglect are at risk of staff failing to report the incident to the appropriate entities. 3. ED will provide education to all staff	

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F 609	Continued From page 2 The CNA stated RN #1 grabbed the resident's hand and forced the resident to take the medication. Further interview revealed the CNA and LPN #1 reported the incident to the DON. b. Interview with LPN #1 on 9/16/21 at 10:08 AM revealed she and CNA #3 observed, on a camera at the nurse's station, resident #30 "swatting" at RN #1. The RN grabbed the resident's arm, placed it on the bed, and knelt on the residents arm with her knee. The LPN and CNA went to the resident's room following the observation. The LPN revealed upon entry in the resident's room, she observed the RN put a spoon full of medications in the resident's mouth, "forced" water into the resident's mouth with a syringe, and placed a "wipe" over the resident's mouth. The LPN stated the resident was trying to yell out and she heard "gurgling" when the resident tried to speak. Further interview revealed the LPN reported the incident to the MDS coordinator and stated the incident occurred at the end of July. c. Review of the State Survey Agency incident report logs failed to show this allegation was reported to the agency as required. d. Interview with the MDS coordinator on 9/16/21 at 10:20 AM revealed she was notified of the incident between resident #30 and RN #1. She did not remember the date the incident was reported to her and confirmed she did not report the allegation further. e. Interview with the DON on 9/16/21 at 8:35 AM revealed she was notified of the incident between resident #30 and RN #1 during an investigation into another incident involving the RN, and further revealed LPN #1 reported she was in the room with RN #1 when the RN leaned on the resident's arm, forced the resident to take medications and water, and covered the	F 609	regarding the importance of reporting an alleged incident immediately and appropriately. Staff will discuss any occurrences or issues of concern with residents during daily rounds. Executive Director will re-educate the Social Service Director and Director of Nursing regarding the reporting requirement to the state survey agency for any allegation of abuse/neglect/exploitation/or mistreatment. 4. ED will complete a 100% audit of investigation log to ensure all allegations of abuse/neglect/exploitation or any mistreatment that are investigated are also reported to the state survey as required by federal regulation weekly for 4 weeks and monthly for 3 months. 5. Results of these audits will be reviewed during the Performance Improvement meetings for three months or until the committee is able to determine the process in place	

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F 609	Continued From page 3 resident's mouth with a tissue to prevent the resident from spitting out the medications. The DON was unsure when the alleged incident occurred. 2. Review of the policy titled "Protection of Residents: Reducing the threat of Abuse & Neglect" last revised on 4/15/19 showed "...Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures..."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		10/31/21

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F 610	Continued From page 4 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and policy and procedure review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 2residents (#30) reviewed for abuse. The findings were: 1. Review of the admission MDS assessment dated 7/21/21 showed resident #30 had diagnoses which included hip fracture, other fracture, non-Alzheimer's dementia, and asthma. Further review showed the resident had a brief interview of mental status (BIMS) score of 6 out 15, which indicated the resident was severely cognitively impaired. The following concerns were identified: a. Interview with CNA #3 on 9/15/21 at 4:35 PM revealed the CNA had observed RN #1 attempting to give the resident medications on a camera monitor at the nurse's station. The resident attempted to refuse the medications and the CNA observed the RN kneel on the resident's arm and put the medications in the resident's mouth. The CNA and another nurse went to the resident's room after the observation on the camera monitor and, after entering the room, observed the resident spit out the medication. The CNA stated the RN grabbed the resident's hand and forced the resident to take the medication. Further interview revealed the CNA and LPN #1 reported the incident to the DON.	F 610	1. Resident #30 remains in the facility. Incident was investigated and reported through state portal. No other reportable occurrences have taken place and no negative outcomes have resulted in the incident not being reported. Staff member was terminated. 2. All residents involved in allegations of abuse or neglect are at risk of ED/DON failing to investigate the incident as required per federal regulation. 3. RVP and RDCS educated the ED and DON regarding the importance of investigating all incidents regarding allegations of abuse/neglect/exploitation or mistreatment of any resident. 4. ED will complete a 100% audit of investigation log to ensure all allegations of abuse/neglect/exploitation or any mistreatment are investigated as required by federal regulation weekly for 4 weeks and monthly for 3 months. ED will report any allegations to RVP to ensure a proper investigation is completed. 5. Results of these audits will be reviewed during the Performance Improvement meetings for three months or until the committee is able to determine the process in place	

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F 610	Continued From page 5 b. Interview with LPN #1 on 9/16/21 at 10:08 AM revealed her and CNA #3 observed, on a camera at the nurse's station, resident #30 "swatting" at RN #1. The RN grabbed the resident's arm, placed it on the bed, and knelt on the resident's arm with her knee. The LPN and CNA went to the resident's room following the observation. The LPN revealed upon entry in the resident's room, she observed as RN #1 put a spoon full of medications in the resident's mouth, "forced" water into the resident's mouth with a syringe, and placed a "wipe" over the resident's mouth. The LPN stated the resident was trying to yell out and she heard "gurgling" when the resident tried to speak. Further interview revealed the LPN reported the incident to the MDS coordinator and stated the incident occurred at the end of July. c. Interview with the DON on 9/16/21 at 8:35 AM revealed she was notified of the incident between resident #30 and RN #1 during an investigation into another incident involving RN #1. Also confirmed an investigation was not conducted. 2. Review of the policy titled "Protection of Residents: Reducing the threat of Abuse & Neglect" last revised on 4/15/19 showed "...In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: ...Have evidence that all alleged violations are thoroughly investigated..."	F 610		
F 656 SS=D	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	F 656		10/31/21

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F 656	Continued From page 6 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 7 Based on medical record review, policy and procedure review, and staff interview the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 19 residents (#5) with care plans reviewed for development. The findings were: 1. Review of the quarterly MDS assessment dated 11/30/20 showed resident #5 was admitted to the facility on 3/13/18 with diagnoses which included Alzheimer's dementia unspecified, unspecified dementia without behavioral disturbance, and unspecified anxiety disorder. Further review showed the resident was coded as "wandering occurred daily." The following concerns were identified: a. Review of the resident's risk assessment dated 9/8/21 showed "resident is at risk for elopement." b. Review of a progress note dated 8/25/21 showed the interdisciplinary team (IDT) documented the resident would "rummage quite often" and roam around looking for his/her deceased spouse. c. Review of the care plan last revised on 8/9/21, showed elopement and wandering were not addressed. d. Interview with LPN #3 on 9/16/21 at 9:25 AM revealed staff did not review care plans often and she was sure the care plan did not "show anything about elopement precautions." 2. Review of the policy and procedure titled "Baseline Care Plan" provided by the facility on 9/16/21 showed "...The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of	F 656	1. Care plan for resident # 5 was updated to reflect any behavioral symptoms including wandering the risk assessment was done in error and has been updated to reflect her actual elopement risk. 2. All residents are at risk of care plans not being person centered and reflecting risk assessment. 3. MDSC will provide education to the Social Services Director regarding updating the care plan to reflect any items that are documented on the risk assessments. 4. DON or designee will conduct random audits of those residents who are at risk for elopement and wandering to ensure the care plan reflects the risk assessment. These audits will be conducted weekly for 4 weeks and monthly for 3 months. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	

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F 656	Continued From page 8 quality care..."	F 656		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, review of the staffing schedule, and policy review, the facility failed to provide sufficient staff for 3 of 3 resident care units (Saddle Ridge, Long Hall, Short Hall). The census was 60. The findings	F 725	No negative outcomes were noted from facility having insufficient staffing. Westview continues to continue hiring efforts. Currently Westview hired two new C.N.A's for night shift and are in the	10/31/21

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F 725	Continued From page 9 were: 1. Group interview with 11 residents on 9/14/21 at 2 PM revealed residents felt they had to wait an extended amount of time to receive assistance during the night shift. Resident #33 stated s/he had to wait for assistance for 1 ½ hours when the facility had 1 CNA working night shift. 2. Interview with resident #3 on 9/14/21 at 11:14 AM revealed the facility did not have enough staff to assist residents and it caused him/her to wait extended periods to get help. Further interview revealed the facility only staffed 1 CNA for 2 halls, usually in the evening and night. 3. Interview with resident #49 on 9/14/21 at 10:09 AM revealed the resident did not feel the facility had enough CNAs to provide resident care. 4. Interview with LPN #3 on 9/15/21 at 8:07 AM revealed the facility was "constantly running short handed on staff," and did not always have the minimum staff needed to provide resident care. 5. Interview with the staff development coordinator on 9/16/21 at 8:17 AM confirmed the facility had 60 residents and the facility was usually staffing 3 CNAs for the night shift. Further interview revealed the facility "tried" to staff for resident needs. 6. Review of the nursing staff schedule for August 2021 showed the facility utilized 2 CNAs for the night shift on 19 of 31 days. Review of the nursing staff schedule for September 2021 showed the facility utilized 2 CNAs for the night shift on 10 of 15 days and utilized 1 CNA for the night shift on 3 of 15 days.	F 725	process of orienting. 2. All residents are at risk of the facility failing to provide sufficient staffing. 3. Facility has continued to use several outlets to post positions, Managers, housekeeping staff and dietary have provided assistance as personal care assistants to ensure the nursing staff have support to care for residents. Nurses will also assist as needed when staffing is less than adequate. Facility has utilized a staffing/labor tool to assist with scheduling and targeted staffing levels. ED has also included a brain storming session with all staff encouraged to add ideas to assist in recruiting and retaining staff. Facility is also conducting a wage analysis. Facility is continuing to provide retention efforts as well. Facility offers and continues to increase sign on bonuses, referral bonuses and pick up bonuses. The facility has made attempts to utilize a staffing agency without success as those agencies did not have sufficient staff to assist as well. The facility has also increased the shift differential to entice more staff to work on evening shift and night shifts. We have added c.n.a staff to assist in the interview process. Attempts made to implement a training/mentor program with all new staff. The facility will continue to try to find new solutions to the staffing crisis. 4. Night nurses and managers will be reminded and reeducated to assist on the floor as needed and to assist in answering call lights when staffing is insufficient. Audit of schedule will be conducted by ED/DON/Scheduler to monitor staffing	

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F 725	Continued From page 10 7. Review of the policy titled "Administrative General Policies" last revised 3/9/21 showed " ...The facility utilizes the Facility Assessment as the foundation to determine staffing levels necessary to ensure that residents' needs are met ..."	F 725	needs including night shift weekly for 4 weeks and monthly for 3 months. Facility will continue to make every effort to find assistance when staffing is not sufficient. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		10/31/21

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F 758	Continued From page 11 §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, review of policy and procedure, and review of a clinical drug resource, the facility failed to ensure unnecessary psychotropic medications were not used for 2 of 5 sample residents (#18, #30) reviewed for medication regimen. The findings were: 1. Review of the quarterly MDS assessment dated 6/24/21 showed resident #18 had a brief interview for mental status (BIMS) score of 2 out 15, which indicated severe cognitive impairment and had diagnoses which included non-Alzheimer's dementia. Further review showed the resident had physical behavioral symptoms and verbal behavioral symptoms directed toward other 4 to 6 days during the look	F 758	1. Care plans for residents #18 and #30 were updated to include targeted behaviors/symptoms for the use of psychotropic medications. Behavior monitoring forms were also updated to include medication section and targeted behaviors/symptoms. 2. All residents who receive psychotropic medications are at risk for care plans and behavior monitoring sheets not reflecting the targeted behavior/symptoms for the use of the particular medication 3. MDSC will provide education to the Social Services director to include the targeted behaviors/symptoms in the care plans and to ensure the behavior monitoring sheets are completed	

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	535039	A. BUILDING _____ B. WING _____	09/16/2021

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F 758	Continued From page 12 back period, but less than daily. Review of the physician orders for September 2021 showed the resident received risperidone (antipsychotic) 1 milligram (mg) by mouth every 12 hours related to unspecified dementia with behaviors, Sertraline (antidepressant) 50 mg by mouth once per day for depression, and clonazepam (sedative/hypnotic) 0.5 mg by mouth at bedtime for dementia. The following concerns were identified: a. Review of the antidepressant medication care plan last revised on 8/16/21 showed medication side effects were identified; however, there were no specific target symptoms for the use of the medication identified. b. Review of the anti-anxiety medication care plan last revised on 8/16/21 showed medication side effects were identified; however, there were no specific target symptoms for the use of the medication identified. c. Review of the psychotropic medication care plan last revised on 8/16/21 showed medication side effects were identified; however, there were no specific target symptoms for the use of the medication identified. d. Review of the "Behavior Monitoring" form provided by the facility on 9/16/21 showed the psychoactive medication sections and target behaviors for the medications were not completed. e. According to Beizer, Semla, and Higbee in "Geriatric Dosage Handbook," 12th edition, 2007, on page 1389: "...Risperidone...Risperidone is not approved for the treatment of dementia-related psychosis..." f. Interview with the social services director on 9/16/21 at 9:26 AM revealed the resident had target symptoms which included exit seeking, verbal and physical aggression, impulsivity, and	F 758	appropriately to include the medication section and targeted symptoms. 4. MDSC will conduct random audits of care plans and behavior monitoring sheets for those residents receiving psychotropic medications. These audits will occur weekly for 4 weeks and monthly for 3 months or until substantial compliance is achieved. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	

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F 758	Continued From page 13	F 758		

packing belongings to leave the facility. Further interview confirmed target symptoms were not identified for each medication the resident used.

2. Review of the admission MDS assessment dated 7/21/21 showed resident #30 had diagnoses which included hip fracture, other fracture, non-Alzheimer's dementia, and asthma. Further review showed the resident had a brief interview of mental status (BIMS) score of 6 out 15, which indicated the resident was severely cognitively impaired. Review of the physician orders for September 2021 showed the resident received quetiapine (antipsychotic) 50 mg by mouth at bedtime for dementia and Trazadone (antidepressant) 50 mg at bedtime for insomnia. The following concerns were identified:

a. Review of the psychotropic medication care plan last revised on 5/27/21showed medication side effects were identified; however, there were no specific target symptoms for the use of the medication identified.

b. Review of the antidepressant medication care plan last revised on 5/27/21 showed medication side effects were identified; however, there were no specific target symptoms for the use of the medication identified.

c. Review of the "Behavior Monitoring" form provided by the facility on 9/16/21 showed the psychoactive medication sections and target behaviors for the medications were not completed.

e. According to Beizer, Semla, and Higbee in "Geriatric Dosage Handbook," 12th edition, 2007, on page 1330: "...Quetiapine...Patients with dementia-related behavioral disorders treated with atypical antipsychotics are at an increased risk of death compared to placebo. Quetiapine is not approved for this indication..."

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F 758	Continued From page 14 d. Interview with the social services director on 9/16/21 at 9:38 AM revealed the resident received Trazadone to help the resident sleep and the quetiapine was for depression. Social service director interview revealed the resident displayed symptoms of crying, self-pity, vocalization of concerns about spouse and marital status, irritability, and verbal abuse. Further interview confirmed target symptoms were not identified for each medication the resident used. 3. Review of the policy titled "Psychotropic Medication Use" last revised on 11/28/16 showed "...Facility staff should take a holistic approach to behavior management that involves thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions...Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms...Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behavior(s)...Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and resident's response to staff interventions..."	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		10/31/21

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F 761	Continued From page 15 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review the facility failed to ensure medications were labeled with an open date and medications available for use were not expired in 3 of 5 medication storage's (Saddle Ridge medication cart, Saddle Ridge medication room, Long Hall medication cart). The findings were: 1. Observation on 9/15/21 at 7:42 AM of the Saddle Ridge medication cart showed 1 Novolog 70-30 suspension 100 unit per milliliter (ml) flex pen was not dated. Further, observation showed 2 insulin Lispro 100 units per ml kwik pens were not dated. Interview with RN #2 at that time	F 761	1. 2 bags of Vanocmycin, 1 bag of Sodium Chloride and 8 2ml vials of ondansetron were properly disposed. Insulin pens were destroyed and new pens were obtained, labeled and appropriately dated 2. All residents who use insulin pens are at risk of receiving medication that is not labeled and dated appropriately. All residents who receive IV medications or injectable medications are at risk of receiving outdated medications. 3. DON or designee will provide education to all nurses regarding disposal	

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F 761	Continued From page 16 confirmed the injection pens were not dated and should have been, and also confirmed the medications were available for resident use. 2. Observation on 9/16/21 at 8:50 AM of the Saddle Ridge medication room showed 2 bags of Vancomycin 50 milligram (mg) per 260 ml bag normal saline solution which had an expiration date of 9/5/21, and 1 bag of 0.9% Sodium Chloride 250 ml solution which had an expiration date of 8/25/21. In addition, there were 8 ondansetron 2 ml vials which had expiration dates of 6/2021. Interview at that time with RN #3 confirmed the medications were for available for resident use and were expired. 3. Observation on 9/16/21 at 9:15 AM of the Long Hall medication cart showed 2 Tresiba flextouch insulin pens with no written open date. Interview at that time with LPN #3 confirmed the medications were available for resident use and were not dated. 4. Review of the policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" last revised on 4/5/19 showed " ...5. ... Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. ... 17. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law..."	F 761	of expired medications including IV and injectable medications. Education will also be provided to nurses regarding labeling and dating medications including insulin pens. 4. DON or designee will conduct random audits on medication carts, medication rooms and medication refrigerators to monitor for any expired medications including IV and injectable medications as well as to ensure medications are labeled and dated appropriately including insulin pens. These audits will be completed weekly for 4 weeks and monthly for 3 months or until substantial compliance has been achieved. 5. Results of this audit will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective. Performance improvement meetings consistent of at a minimum the Executive Director, Director of Nursing, and Medical Director, and additional staff as needed. The Performance Improvement committee identifies issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies.	