STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY LIVING AND REHABILITATION CENTER	**1000 S DOUGLAS HWY GILLETTE, WY 82716**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 11/29/21 to 12/2/21. Also reviewed in the course of the survey were complaint intakes WY00003318 and WY00003322. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CMS- Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		1/16/22

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

Electronically Signed | 12/24/2021

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure the residents' rights to self-determination and communication and access to persons inside the facility was facilitated for 2 of 4 resident units (Birch, Spruce). The findings were: Interview with a resident group on 11/30/21 at 12:32 PM revealed the facility had not allowed communal dining for "almost 2 years" and activities were performed with residents in their	F 550	Immediate corrections: Nursing and nutrition staff were mobilized and educated on communal dining process the week of December 6th, including mitigation of staffing shortage to accommodate the process. Communal dining was started on Monday, 12/13/21. House Supervisors rounded and educated staff about communal dining. An additional e-mail with the process was sent to all nursing staff, Dining Service	

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F 550	Continued From page 2 rooms. Further interview revealed some of the residents felt like "prisoners" because of COVID restrictions still in place. The following concerns were identified: a. Interview with the infection preventionist on 12/2/21 at 12:34 PM revealed residents could come out of their rooms for group activities and communal dining for those who required assistance. She revealed 83% of residents had been vaccinated; however, the facility had not provided information to inform them about participating in communal dining and group activities. Further interview revealed the facility had not implemented communal dining for all residents due to training needs for staff and had been working on a plan to reinstate communal dining since October 2021. b. Interview with the dietary manager on 12/2/21 at 9:50 AM revealed they were currently in development with nursing to open dining for resident's on the Birch and Spruce units. c. Review of CMS guidance found in QSO-20 -39-NH, "Nursing Home Visitation-COVID-19" revised 11/12/21 showed"...While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur..."	F 550	Director, and Dietician on 12/13/21. Nursing unit staff and House Supervisors rounded on residents to inform them of communal dining prior to start date. Identification of other residents: All residents were potentially affected. Systematic changes and monitoring: By 1/7/22, a clinical alert will be created to load to the dashboard when a resident does not eat 75% or more of their meals in the dining room. Residents who trigger this alert will be evaluated for barriers to participation to ensure their ability to choose communal dining is supported. Review and revision of policy, Room Trays during COVID by 1/14/22. Education for communal dining will be in January All-Staff education, with due date of 1/16/22. QAPI team will monitor systematic changes until resolution. Outcome: Effective 12/13/21, residents are now provided a communal dining experience for all meals. By 3/1/22, all residents who participate in less than 75% of communal dining will be addressed via mitigation of barriers or careplanning of alternated dining preferences.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		1/16/22

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F 679	Continued From page 3 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, review of activity participation notes, and policy and procedure review, the facility failed to ensure an activity program was implemented for 3 of 8 sample residents (#19, #32, #104) reviewed for activities. The findings were: 1. Review of the 9/13/21 quarterly MDS assessment showed resident #32 had diagnoses that included anxiety and seizure disorder. The resident had severe cognitive impairment with a BIMS score of 7 out of 15, required extensive assistance with 1 person physical assist for transfers, and required supervision, oversight, encouragement or cueing for eating, with set up help only. Review of the care plan dated 4/6/20 showed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs. The approaches included "...Will encourage involvement in 1:1 and small group activities during times of visitation restriction...Provide means of communication with family via IPad, phone, etc. during times of visitation restriction...The resident prefers the following TV channels: Hallmark channel, new channels, movie channels, channel surfing...The resident's preferred activities are: Bingo, Nailcare, art & crafts and special entertainment."	F 679	Immediate corrections: Resident #19 □ this resident has documented refusals of functional maintenance program, with documented modifications therapy created to accommodate resident preference to stay in her room. Resident has been approached by activities multiple times to encourage her to join activities, without success and despite offerings that are enjoyable to her. Minimal success with 1:1 offerings. Activities team was educated on 12/6/21 on the expectations of documenting resident participation, refusals, and choices offered. Care team will meet by 12/31/21 to establish a plan of action to more effectively address lack of participation. Resident #32 □ resident participated in BINGO on 12/6, 12/10, 12/13, 12/17, and 12/20. Resident also participate in Christmas Trivia on 12/9 and was a judge in the Christmas Decor Contest on 12/16. Resident #104 □ resident participated in BINGO on 12/6, 12/17, and 12/20; participated in nail care on 12/7/21; Group exercise on 12/8; Christmas charades 12/8; Resident Council on 12/15; judging Christmas decor on 12/16; felt candy tree	

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F 679	Continued From page 4 Observation on 11/30/21 at 10:45 AM showed the door to the resident's room was closed and there was personal protective equipment available in a container on the closed door. Review of the care plan showed on 11/24/21 contact isolation was initiated due to a shingles infection. The shingles lesions were located on the resident's right forehead and front scalp. The following concerns were identified: a. Interview on 12/01/21 at 12:14 PM with activity aide #1 revealed since the resident had been on isolation, she had not been in the resident's room, and was not aware of any plan to provide activities. b. Review of the activity participation notes dated 11/4/21 and 11/1/21 showed the resident had compassionate care visits with family on these days. There were no other notes or details documented related to activities provided or participated in for the month of November 2021. c. Interview with the activity director on 12/02/21 at 11:51 AM confirmed when the resident was placed on isolation, there should have been 1:1 activities provided. The expectation would be for the activity aide to offer activities based on the resident's known activity preferences. 2. Review of the 10/27/21 quarterly MDS assessment showed resident #104 was admitted to the facility on 6/7/21 with diagnoses that included anxiety and depression, and had a BIMS score of 15, showing s/he was cognitively intact. Further review showed it was very important to the resident to have books, newspapers, and magazines to read, music to listen to, to be around animals, to keep up with the news, to do things with groups of people, to do his/her favorite activities, to go outside, and to participate in	F 679	craft on 12/21/21 Activities has implemented a second activity on the calendar starting 12/6/21, residents notified per facility process (activities calendar). On 12/6/21, daily activities huddles on units were implemented to review residents on isolation and ensure 1:1 visits are offered and that care plans reflected this need. On 12/13/21, verbal education provided to float staff on how to document 1:1 visits. Identification of other residents: By January 16, 2022, the facility will review 100% of activities assessments and care plans to ensure activity needs are being met and that care plans are up to date and reflective of resident preferences. Weekly Leadership rounding to be done on all units to validate activities are occurring as planned, and to observe quality of resident participation. Systematic changes and monitoring: Review and revision of the following policies: Activity One to One Visits, Resident council, Activity assessment/evaluation by 1/14/22 Education to activities department on policy/procedure updates, care plan and documentation expectations, and regulatory intent of Activities program by 1/14/22 Educate all staff on activity program and	

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F 679	Continued From page 5 religious services or practices. Review of a 6/10/21 progress note documenting Resident Preferences Evaluation showed " ...activity staff will continue to monitor resident for any concerns that may arise. 1-1 visit will be as needed." The following concerns were identified: a. Interview with the resident on 11/30/21 at 11:11 AM revealed s/he tried to go to social activities, but hadn't been able to since the facility was under quarantine status. S/he further stated " ...there hasn't been much to do except watch tv." b. Review of the resident's 1:1 activity participation documentation for the previous 14 days from 12/1/21 showed only three 1:1 activities were offered or provided during that time. c. Review of the November 2021 Event Calendar Report for 11/1/21 to 11/25/21 showed 7 days in which the resident was not invited to activities, and 9 days in which she was invited but chose not to attend or was unable to attend; review of the medical record showed no documentation indicating alternative or 1:1 activities were offered as replacements during those occasions. d. Review of the resident's Activity Participation Notes since the 6/7/21 admission showed only 14 notes related to activity engagement for the resident, including offered activities, participation, and refusals. e. Review of the current, undated activity care plan showed interventions that included "Invite the resident to scheduled activities ...Notify resident of any changes to the calendar of activities...socializing with staff and residents, and with family via personal cellphone and his/her computer or Facebook." Preferred activities included television, nail care, planting flowers, bingo, resident counsel, arts and crafts, and	F 679	policy and procedures to be completed by 1/16/22. Monthly audit of activity calendar to verify that residents were provided a choice of activities, received notification/invites, and were updated of any changes to the calendar prior to the event. This audit will begin in January 2022 (first month audited is December 2021). Beginning 1/7/22, weekly audits on each 40-bed wing, with a sample size of 5 residents per wing. Audit to cover the following: care plans reflect current resident activity preferences and needs, choice of activities offered to them, and resident actual participation (including reasons for refusal). When 100% of audit sample meets expectation for 4 consecutive audits, audit frequency will decrease to monthly. Unsuccessful audits will result in resuming weekly reviews until parameters met. QAPI team will monitor until resolution. Outcome: 100% of residents will have a current, individualized care plan reflecting resident preference, be offered meaningful activity choices that are pertinent to resident needs, and documentation of participation or documented interventions if residents refused.	

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F 679	Continued From page 6	F 679		

spending time outdoors.

3. Review of the 8/29/21 quarterly MDS showed resident #19 was admitted to the facility on 6/3/18 with diagnoses that included depression, and had a BIMS score of 15, showing s/he was cognitively intact. Further review showed it was very important to the resident to do his/her favorite activities and to go outside. The following concerns were identified:

a. Interview with the resident on 11/30/21 at 10:39 AM revealed the facility offered some activities to him/her, but they are only things out of his/her room and not offered very often. S/he further stated she worries about Covid, and chooses to stay in her room most of the time. S/he also stated activities options for residents who choose to stay in their rooms, or when the facility is on quarantine, are "...minimal to none."

b. Review of Activity Participation Notes and progress notes for the previous 6 months showed the resident participated in or was offered 1:1 activity time a few times each week during July 2021 and August 2021. However, 9/7/21 was the only date activities were documented for the resident during September 2021; further, no activity offer or engagement was documented from 10/20/21 through 11/2/21, or from 11/4/21 through 11/30/21. Further review showed the resident's documented 1:1 activity time consisted of conversation and nail care, and 5 of the sessions documented as activities only involved communication with the resident regarding a tv remote, laundry issues, and a broken necklace.

c. Review of the resident's current undated activity care plan showed interventions that included "Provide with activities calendar. Notify resident of any changes to the calendar of activities", "The resident's preferred activities are:

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F 679	Continued From page 7	F 679		

Independent activities in room - Computer ... Watching Classic movies ... Caring for her plants ... Resident will occasionally attend group activities ... Bingo, Nailcare ..."

4. Review of the unit activity calendar for 11/1/21 to 12/4/21 showed from November 1st to 12th, only one activity was offered each day, with only 4 days offering more than one activity; it was also noted no activities were offered on the weekends during that time. Further review showed November 14th to December 4th offered only one activity each day, with only 5 days offering more than one activity; it was also noted no activity was offered on Thanksgiving.

5. Interview with activity director on 12/2/21 at 11:51 AM revealed the facility activity staff only performed 1 activity per day on each unit which should occur each day. The activity was determined by resident needs through the resident assessment. She revealed if residents did not attend activities, 1 to 1 activities should be performed for the residents. Further interview revealed the facility could increase activities; however, at times, activity staff is pulled to assist in other areas because of staffing challenges which prevented activities from always occurring as scheduled.

6. Interview with the Activity Director on 12/2/21 at 11:54 AM confirmed documentation of activities " ...is lacking, and not all residents are getting the activities [the facility] provided ..." She further confirmed resident #19 chose to stay in his/her room, and didn't always get 1:1 time. She also stated not all residents get their 1:1 time when requested, or when it is appropriate due to limits on group activities.

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F 679	Continued From page 8 7. Review of the facility policy "Activity Assessment/Evaluation" last revised on 1/16/20 showed "...Activities will be designed to be meaningful and appropriate to the needs and interests of residents. The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community..."	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, resident and staff interview, the facility failed to ensure appropriate	F 686	Immediate corrections: Resident #53 □ Wound care orders were changed 12/2/21 to help promote more	1/16/22

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F 686	Continued From page 9 wound assessment and documentation for 1 of 6 sample residents (#53) reviewed for pressure injuries. The findings were: 1. Review of the quarterly MDS assessment dated 9/27/21 showed resident #53 had a BIMS score of 5 of 15 out which indicated severe cognitive impairment, and had diagnoses which included non-Alzheimer's dementia, pressure ulcer of right buttock, and sarcopenia. Further review showed the resident was at risk for pressure ulcer development and had a stage II pressure ulcer. Observation on 11/30/21 on 11:37 AM showed the resident was in his/her room, positioned in a recliner next to the bed and had an air mattress in place on the bed. Observation on 12/1/21 at 10:15 AM showed the resident was in his/her room, positioned in a recliner. Interview with the resident at that time revealed s/he had a wound to his/her buttocks and the dressing change "went well" earlier that day. The following concerns were identified: a. Observation on 12/2/21 at 9:25 AM showed nurse practitioner #1 and nurse practitioner #2, and physical therapist #1, entered the resident's room and repositioned the resident to his/her right side to expose two dressings near the resident's coccyx, 1 on the left buttock and 1 on the right buttock. Nurse practitioner #1 removed the resident's dressings which exposed an open area to the upper left buttock and an open area to the upper right buttock. The nurse practitioner measured the right buttock wound as 2 cm by 0.8 cm and the left buttock wound as 1.9 cm by 1.4 cm. b. Review of a "E-Z Graph Wound Assessment Worksheet" dated 11/18/21 showed the resident had a "stage 2" wound to his/her right buttock which measured 2.1 cm by 1.3 cm. There	F 686	regular dressing changes, more frequent visualization of the wound, and increased resident offloading/turning which he had been previously resistance. As of 12/21/21, one of the two wounds is healed from this particular order change. Proof Identification of other residents: On 12/20/21, the following process was implemented: Wound Care Coordinator pulls Risk Management report daily to identify new or worsening skin issues and evaluates that resident within 24 hours. Weekly, the wound care coordinator updates a spreadsheet tool that captures the in-depth wound data (measurements, interventions, progress, etc) and uses this tool to coordinate efforts of wound team. Wound rounds with providers occur weekly on new or worsening wounds, and all pressure ulcers. Systematic changes and monitoring: Wound Care Performance Improvement Project (PIP) was already in place at time of survey. Goal is prompt initiation of wound care nursing protocols and effective coordination between nursing staff and providers. Through this PIP, education is provided to nursing staff on criteria for documentation, wound dressing applications, proper identification and measurement, and care planning interventions/preventative measures for at risk individuals. Effective 12/15/21, PIP is focusing on education of proper documentation and care planning. Review and revision of policy, Wound and Skin Precautions	

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F 686	Continued From page 10 was no indication the resident had a wound to the left buttock. c. Review of a "Skin and Wound Evaluation" dated 11/25/21 showed the resident had a "pressure injury" which was a "stage II" to "buttock." Further review showed no wound measurements, if the wound was located on the right or left buttock, or indication there was more than 1 pressure injury. d. Review of a "Skin and Wound Evaluation" dated 11/27/21 showed the resident had "pressure injury" which was "stage II" to "buttocks." Further review showed no wound measurements or the position of the wounds on the resident's buttocks. e. Review of a "Skin and Wound Evaluation" dated 11/29/21 showed the resident had "stage II" pressure ulcers with "Partial Thickness" to "bilateral buttock." Further review showed no wound measurements or the position of the wounds on the resident's buttocks. f. Interview with nurse practitioner #1, nurse practitioner #2, and physical therapist #1 on 12/2/21 at 1:43 PM revealed as a team, they followed all wounds at the facility. The interview revealed the first time the team observed the left buttock wound was during the observation on 12/2/21. Physical therapist #1 revealed the dressing change to the right buttock had not been performed between 11/19/21 and 11/29/21. The physical therapist revealed he observed the left buttock wound on 11/29/21 when he performed the dressing change on the right buttock. Further interview with the team revealed the expectation was for staff to complete a concern form to be sent to the wound team to notify them of new wounds when new wounds were observed. 2. Review of the policy titled "Wound and Skin	F 686	Review and revision of policy, Wound Vac Management QAPI team will monitor until resolution. Outcome: Audit interventions and wound characteristics for 100% of all pressure ulcers within the facility weekly from 1/1/22 to 12/13/22. 100% of residents identified through audits will have individualized interventions, appropriate wound documentation, and updated care plans.	

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F 686	Continued From page 11 Precautions/Care/Pressure Ulcer Prevention" last revised on 5/1/21 showed "...7. Any Pressure Ulcer or Suspected Deep Tissue Injury must be reported in Midas Pressure Ulcer Report...Standard of Performance: 1. Nursing will coordinate care by including the patient, appropriate members of the family and skin care team (staff nurse, physician, dietitian, physical therapist, discharge planner, and occupational therapist if indicated)..."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure supervision during meals was provided as planned for 1 of 6 sample residents (#32) reviewed for safety. The findings were: Review of the 9/13/21 quarterly MDS assessment showed resident #32 had diagnoses that included anxiety and seizure disorder. The resident had severe cognitive impairment with a BIMS score of 7 out of 15, required extensive assistance with 1 person physical assist for transfers and required supervision, oversight, encouragement or cueing for eating, with set up help only. Review of the care plan revised on 10/14/21 showed the	F 689	Immediate corrections: Resident #32: care plan reviewed and therapy screen performed on 12/3/21 to ensure resident□s level of supervision is appropriate. Education sent to staff regarding this resident□s need for supervision during times of isolation. Completed 12/21/21 Identification of other residents: By 12/31/21, House Supervisors will educate staff on current process of entering an order when a resident goes on precautions. On 12/23/21, House Supervisors will run	1/16/22

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F 689	Continued From page 12	F 689		

resident was at high risk for falls related to seizure disorder. The following approaches were included: "...Resident is very limited in ability to ambulate at this time related to increased seizure activity, and weakness...Requires supportive reminders for call light use as resident tends to forget or choose not to ask...Increase rounding intervals during times of higher seizure activity...Resident needs to be up in her wheelchair and supervised during meals. Resident will eat [his/her] meals in the activity dining room..." The following concerns were identified:

a. Observation on 11/30/21 at 12:09 PM showed the resident was staying in his/her room due to isolation precautions. CNA #1 removed her PPE in the room after setting up the resident's room tray and closed the room door when she exited. At that time, interview with the CNA stated the resident did not require assistance just set up help for the meal.

b. Observation on 12/1/21 at 12:37 PM showed CNA #1 delivered the resident's lunch tray with her PPE on. The resident could be seen through the door and was up in his/her wheelchair with the meal on an over bed table. When the CNA exited the room, she closed the door behind her.

c. Interview on 12/1/21 at 12:37 PM with CNA #2 who was passing trays in the hallway, stated the resident was on seizure precautions and usually came out to the dining room so they could "watch" him/her. However, the resident had a shingles infection and had been eating in his/her room unattended. The aide stated the infection was on the resident's face and it could not be effectively covered in order for him/her to come out to the dining room.

d. Interview on 12/1/21 at 12:37 PM with

an order listing report daily to identify precaution orders and update 24-Hour Report.

Systematic changes and monitoring:
Review and revision of transmission precautions policy by 1/14/22 to ensure that facility continues to provide a safe environment and maintain quality of life and resident rights.
Education on policy, and expectations of maintaining safety and quality of life for residents on transmission precautions will be provided in January All-Staff education, due date 1/16/22.
100% of isolated residents to be audited weekly starting 1/16/22. If 100% compliance for 4 consecutive weeks, audits will be performed monthly on a sample of 5 residents on isolation. Unsuccessful audits will result in resuming weekly reviews until parameters met. QAPI team will monitor until resolution.

Outcome:
100% of residents on isolation will have documented evidence that activities needs, safety needs, functional maintenance needs, communication needs, supervision needs (ie, meals) have been addressed within the first 12 hours of isolation.

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F 689	Continued From page 13 CNAs #1 and #2 revealed they set up the resident's meals and then rounded on him/her every 20-30 minutes or if s/he called. e. Interview on 12/02/21 at 9:56 AM with RN #1 revealed the resident had orders that morning to have the contact isolation discontinued. The RN also stated the rationale for the supervision during dining was related to seizure activity and the possibility for swallowing issues if a seizure were to occur. She stated the increased rounding the CNAs talked about doing while on isolation was not documented. f. Interview with the infection preventionist on 12/2/21 at 12:40 PM confirmed she was aware of the resident's need for contact precautions. She stated in order to maintain consistency the staff were taught to keep doors closed for any type of isolation precautions. Further, she stated in this case the door would not be required to be kept closed; however, there had been no discussion regarding special needs for this resident.	F 689		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview,	F 740	Immediate corrections:	1/16/22

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F 740	Continued From page 14 review of activity participation notes, and review of facility policy and procedure, the facility failed to identify and address behavioral health care needs for 1 of 5 sample residents (#73) with symptoms of depression. The findings were: Review of the 10/8/21 significant change MDS assessment showed resident #73 had diagnoses that included: dementia, coronary artery disease, heart failure and diabetes mellitus. The resident required extensive assistance for ADLs with the exception of eating and was coded as having moderate cognitive impairment for daily decision making. According to the assessment the resident showed mood symptoms that included "Little interest or pleasure in doing things (nearly every day)... feeling or appearing down, depressed or hopeless, (several days)... trouble falling or staying asleep, or sleeping too much (nearly every day)." Review of the care plan last revised on 1/11/21 showed "Monitor/document/report PRN [as needed] any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness." Review of the physician orders showed the resident was not receiving any anti-depressant medications. The following concerns were identified: a. Review of the activity participation note dated 11/2/21 at 1:32 PM showed: "While visiting with resident today, all [s/he] could say [was] that [s/he] would be better off dying [because] cause [s/he] has no friends and has nothing. Resident would only say that [s/he] would be better off if	F 740	Resident #73 □ BIMS and PHQ-9 completed on 12/2/21 with documentation to include a SS progress note and communication to the provider. Education to nursing staff on when and how to communicate any behavioral health concerns regarding residents. Completed on 12/14/21. Education to all staff, completed on 12/23/21. Identification of other residents: By 1/16/21, 100% of PHQ-9 Scores will be evaluated and compared to previous score. SS will assess any resident with a worsening PHQ-9 score or indicators on the most recent assessment of behavioral health concerns. All concerns will be reported immediately to the providers and nursing leadership for further assessment. Systematic changes and monitoring: Ensure that facility policies sufficiently address the following by 1/16/22: Management of behavioral health concerns including suicidal ideations; Appropriate MDS documentation and frequency relevant to behavioral health concerns, including implementation of care plans, timely communication, intervention, and follow up of behavioral health concerns by the interdisciplinary team All staff education on above will be provided to staff by 1/16/22. 100% of PHQ-9 scores will be reviewed based on MDS schedule and protocol. This will occur monthly times 12 months.	

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F 740	Continued From page 15 [s/he] didn't wake up and they could put 'me in the ground' and all [his/her] problems would be solved." Continued review of the resident's record failed to show any follow up related to this note. b. Interview with the DON on 12/2/21 at 11:47 AM revealed to her knowledge nursing had not been notified of the concerns with the resident. c. Review of an email dated 11/2/21 at 3:45 PM showed activity assistant #1, who wrote the note in the medical record, informed the two social services staff members of the resident's statements. The email showed the resident may need "counseling" and "I don't know what else to do but to inform you two about it." d. Interview with the social services director on 12/02/21 at 10:06 AM confirmed she recalled visiting the resident after receiving the information; however, there was nothing documented. She further confirmed she was unable to find any notification to the physician/provider regarding the resident's statements and mood from that date. e. Review of the social service note dated 12/2/21 at 2:48 PM showed a new PHQ9 (depression assessment) was done with the resident and s/he answered "yes to question D0200-I; thoughts you would be better off dead or of hurting yourself." The note further documented the resident denied thoughts of self-harm and denied feeling suicidal. The note further showed the resident's physician/provider had been notified. f. Review of the policy "Suicide Threats/Ideation" revised 2/2021 showed "Staff shall report any resident threats of suicide immediately to the unit charge nurse...the charge nurse shall immediately assess/evaluate the situation and shall notify the House Supervisor and/or Director of Nursing Services of such	F 740	QAPI team will monitor until resolution. Outcome: 100% of residents triggering PHQ-9 change will documented follow-up and individualized care plans reflecting necessary interventions.	

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F 740	Continued From page 16 threats...after assessing/evaluating the resident in more detail, the charge nurse shall notify the resident's Attending Provider, and shall seek further direction from the provider..."	F 740		
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; §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	F 758		1/16/22

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F 758	Continued From page 17 §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 observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure psychotropic medications were necessary for 2 of 5 sample residents (#42, #51) reviewed for unnecessary medication use. The findings were: 1. Review of the quarterly MDS assessment dated 9/9/21 showed resident #42 had a BIMS score of 0 out 15 which indicated severe cognitive impairment and diagnoses which included non-Alzheimer's dementia, intervertebral disc displacement in the lumbar region, adjustment disorder with depressed mood, and insomnia. Further review showed the resident required extensive physical assistance of 2 or more people for bed mobility and toilet use, and extensive physical assistance of 1 person for personal hygiene, transfers, locomotion on and off the unit, and dressing. Review of the annual MDS assessment dated 6/9/21 showed the resident assessment indicated it was "Very important" for	F 758	Immediate corrections: Resident #42 □ Resident was already being addressed through interdisciplinary team due to decline in function leading to continual 1:1 care needs. Provider was in discussion with family regarding hospice, to which they declined. Nonpharmacological interventions already in place via activities, and the resident was a regular participant (2-3 times per week). Resident continued with activities after the survey on 12/3 (crafts), 12/4 (exercise and music), and 12/5 (hymn singing). Resident admitted to hospital on 12/6 due to continuing decline. Acute care also unsuccessful with family regarding hospice. Resident passed away on 12/11. The plan of corrections outlined below is addressing issues with documentation and target behavior monitoring process that pertain to this resident citation. Resident #51 □ review of target behaviors	

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F 758	Continued From page 18 the resident to have books, newspapers, and magazines to read, music the resident the liked to listen to, participate in religious services, to go outside when the weather was good, and participate in his/her favorite activities. The following concerns were identified: a. Observation on 11/30/21 at 11 AM showed the resident was seated in a recliner in the TV room with his/her eyes closed, and a neck pillow to position the resident's head. Unidentified staff members transferred the resident from the recliner to a wheelchair, and assisted him/her to the dining area for lunch. The resident remained with his/her eyes closed and did not participate in eating the meal. Further observation showed a visitor arrived and attempted to assist the resident to eat, without success. Staff assisted the resident out of the dining area to the TV room to visit with the resident. The resident continued to rest with his/her eyes closed during the visit, until the visitor left the facility. b. Observation on 12/1/21 at 9:43 AM showed the resident was seated in a recliner in the TV room with his/her eyes closed, while a Christmas movie played on the television. Unidentified staff members assisted the resident to transfer to a wheelchair for therapy services. c. Review of the physician orders dated 12/1/21 showed the resident received haloperidol (antipsychotic) 2 mg by mouth twice per day for dementia with behavioral disturbance, lorazepam (benzodiazepine) 0.5 mg by mouth every 6 hours for anxiety, agitation, and restlessness, and sertraline (antidepressant) 100 mg by mouth daily for depression. d. Review of the medication administration record (MAR) for December 2021 showed "TARGET BEHAVIORS - MONITOR FOR THE FOLLOWING: Depression, Sadness, tearfulness,	F 758	by medication and update of target behavior monitoring by 12/31/21. Identification of other residents: By 1/7/22, nursing will give providers a summary of applicable target behaviors for each resident receiving psychotropic medications. Providers will compare this summary against current orders, updating target behaviors as appropriate. All updates will be completed by January 31, 2022 Systematic changes and monitoring: Review and revisions of policy, Psychoactive Medications Use and Monitoring by 1/31/22 Education to providers on specifying target behaviors to monitor, to be completed by 1/7/22. Education to floor staff (RN/LPN) regarding creating target behavior monitoring TAR items, to be completed by 1/31/22. QAPI team will monitor until resolution. Outcome: Pharmacy meeting occurs monthly. All residents up for review each month will be audited for appropriate target behaviors. Success evidenced by three audit cycles where 100% of residents reviewed will have appropriate target behaviors with updates to TAR and care plan. If successful, sample size of monthly audit will be reduced to 10 per month.	

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withdrawal, dementia behaviors, restlessness, and agitation. two times a day Chart how often each behavior is
seen. -Start Date-01/14/2021 1700." Further review showed no evidence which of the target behaviors were being monitored for each of the psychotropic medications used.

e. Review of the resident's care plan last revised on 6/30/21 showed "Behavior Management r/t [related to] dementia, a.e.b [as evidenced by] poor decision making and uncontrollable mood swings and delusional thoughts." Interventions included "Encourage participation in self-calming behaviors such as breathing exercises, meditation, or guided imagery... Ensure the safety of Resident and others... Establish boundaries and limits with Resident... Evaluate medication schedule and possible pharmacologic causes of repetitive behavior... Monitor for cognitive factors that may contribute to new behavior(s)... Monitor for emotional factors that may contribute to new behaviors(s)...Monitor for signs/symptoms of infection...Notify family of new onset finding...Notify provider of new onset finding...Provide emotional support regarding new onset of repetitive behaviors...Utilize diversion techniques as needed..." Further review showed no specific target symptoms identified for each psychotropic medication used or resident specific non-pharmacological interventions.

f. Interview with CNA #3 on 12/2/21 at 9 AM revealed the resident usually slept all day in the chair since s/he started taking medications to prevent him/her from getting up and down which had resulted in "a lot of falls." Before the medication was started, the resident enjoyed going for walks, looking at pictures of kids, and having snacks when s/he was having behaviors;

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however, the resident no longer participated in those activities routinely.

2. Review of the quarterly MDS assessment dated 9/24/21 showed resident #51 had a BIMS score of 3 out 15 which indicated severe cognitive impairment and had diagnoses which included non-Alzheimer's dementia, anxiety disorder, depression, insomnia, and adjustment disorder with depressed mood. Review of the annual MDS assessment dated 1/13/21 showed the resident assessment indicated it was "very important" to participate in in religious services and "somewhat important" to participate in music the resident the liked to listen to and keeping up with the news. The following concerns were identified:

a. Review of the MAR for December 2021 showed the resident received duloxetine (antidepressant) 60 mg by mouth every day for depression, mirtazapine (antidepressant) 7.5 mg by mouth every day for depression and insomnia, and quetiapine 25 mg by mouth at bedtime for aggression towards self and others. Further review showed "TARGET BEHAVIORS-MONITOR FOR THE FOLLOWING: depression, insomnia, dementia with anxiety and agitation two times a day..." There was no evidence which of the target behaviors were being monitored for each psychotropic medications used.

b. Interview with CNA #3 on 12/2/21 at 9:02 AM revealed the resident laid in bed all day every day and would hit or yell at staff. Further interview revealed the resident liked milk and cookies and could be redirected if staff provided space before attempting to re-approach him/her.

3. Interview with the DON on 12/2/21 at 10:49 AM revealed the facility utilized duplicate therapy to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 21	F 758		

treat the same symptoms for the residents so the behaviors being tracked applied to all psychotropic medications the residents were ordered. Further interview revealed the interdisciplinary team (IDT) reviewed medications and behaviors to determine a need for risk vs benefit or gradual dose reduction (GDR) to provide recommendations to the physician. The determination to perform a GDR was up to the provider's discretion after they reviewed the behavior notes and target behaviors.

2. Review of the policy titled "Psychoactive Medication Use and Monitoring" last revised on 10/18/21 showed "...2. The Attending Provider and other staff will gather and document information to clarify a resident's behavior, mood, function, medial condition, symptoms, and risks and document indication for medication. a) "indications for use" is the identified, documented clinical rationale for administering a medication based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. b) The evaluation also clarifies: Whether other causes for the symptoms (including expressions or indications of distress that could mimic a psychiatric disorder) have been ruled out; Whether the physical, mental, behavioral, and/or psychosocial signs, symptoms, or related causes are persistent or clinically significant enough (e.g., causing functional decline) to warrant the initiation or continuation of medication therapy; whether non-pharmacological approaches are implemented, unless clinically contraindicated for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 12/02/2021

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F 758	Continued From page 22 the resident or declined by the resident...5. Based on assessment/evaluation of the resident's symptoms and overall situation, the Provider will determine whether to continue, adjust, or stop existing psychoactive medication..."	F 758		