STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	**4041 SOUTH POPLAR STREET CASPER, WY 82601**

(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 7/25/22 to 7/28/22. Also reviewed in the course of the survey were complaint intakes WY00003428, WY00003432, and WY00003446. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,	F 561		9/21/22

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

Electronically Signed | 08/19/2022

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F 561	Continued From page 1 assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff and resident interview, the facility failed to ensure health care treatments were scheduled in accordance with residents' preferred sleeping schedules for 1 of 18 (#44) sample residents reviewed. The findings were: 1. Review of the 6/16/22 admission MDS assessment showed resident #44 was admitted to the facility on 6/10/22 and had a BIMS score of 15/15 which indicated the resident was cognitively intact. Further review showed the resident was admitted with two stage 4 pressure ulcers, and one unstageable pressure ulcer. Review of a 7/14/22 physician order showed the resident was to have the stage 4 pressure ulcer located on the left buttock, cleaned with saline and gauze, the cavity filled with Dakin's Solution (an antiseptic used to clean wounds) soaked gauze, and covered with a composite dressing twice a day	F 561	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 because it is required by the provisions of the state and federal law. For the purposes of any allegations that the facility is not in substantial compliance with federal requirement for participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. 1. Problem Statement: The facility failed to ensure health care	

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F 561	Continued From page 2 and as needed. In addition, on 7/5/22 the resident was prescribed one 5-325 milligram tablet of hydrocodone-acetaminophen (a narcotic for pain relief) to be administered 30 to 45 minutes prior to dressing changes. The following concerns were identified: a. Interview with the resident on 7/26/22 at 9:56 AM revealed s/he had a pressure ulcer which required a dressing change every 12 hours, and she was given pain medication 30 to 45 minutes before the procedure. The resident stated s/he had informed the nurses that s/he preferred to go to sleep around 9:30 PM to 10 PM, however felt there was not any "continuity of care" and s/he "was at the bottom of the totem pole" because the dressing change often occurred later than 9:30 PM. In addition the resident revealed s/he had to either wait until the second dressing change of the day had been completed or be woken up to have it done. Further the resident stated it was hard to go back to sleep after being woken up. b. Review of the July 2022 medication administration record showed the hydrocodone-acetaminophen medication was administered at 9 PM on 7/15; 9:33 PM on 7/19; 10:11 PM on 7/20; 9:49 PM on 7/21, 9:23 PM on 7/25; 9:56 PM on 7/26; and 10 PM on 7/27. c. Interview with RN #1 on 7/27/22 at 11:47 AM revealed the resident was scheduled for a dressing change between 6 AM and 10 AM and again between 6 PM and 10 PM. RN #1 confirmed the resident received medication for pain 30 to 45 minutes before the procedure. d. Interview with RN #2 on 7/27/22 at 6:25 PM revealed she worked the 6 PM to 10 PM shift and would do the resident's dressing change if she had time; otherwise she would leave it for the night shift nurse.	F 561	treatments were scheduled in accordance with resident # 44 of the sample of residents preferred sleeping schedules 2. Corrective Action: DON/Designee interviewed resident to determine best time to schedule wound care. Wound care was scheduled per resident (#44) preference. 3. Identification of Others: DON/Designee identified residents with wounds in house, interviewed residents for their preference of time for treatment/dressing changes then were scheduled accordingly to their preference. 4. Systemic Changes: Education done with 100% of all nurses will be done by 8/17/2022. New admissions with wounds will be asked for their preference of time of day for their wound care treatments. 5. Ongoing: DON/Designee will interview 3 residents weekly x 4 weeks, then monthly x 2 months to ensure wound care is being done at the time agreed upon. 6. Results of these audits completed by the DON or designee will be reviewed at the Performance Improvement meetings monthly for three months or until substantial compliance has been met.	

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F 561	Continued From page 3 e. An additional interview with the resident on 7/28/22 at 9:47 AM revealed s/he had been given the pain medication around 10 PM the previous evening; the dressing change was started at approximately 10:40 PM and was completed at 11 PM. f. Interview with the DON on 7/28/22 at 11:43 AM revealed it should be the resident's choice as to what time the dressing changes should occur.	F 561	Performance improvement meetings consist of at a minimum the Executive Director, Director of Nursing, the 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.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		9/21/22

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F 623	Continued From page 4 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623		

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F 623	Continued From page 5 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). 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 residents or residents' representatives received a written transfer notice for 5 of 5 sample residents (#1, #19, #56, #73, #173) reviewed for hospitalization. The findings were: 1. Review of a progress dated 7/16/22 and timed 5:06 PM showed resident #1 had not been at	F 623	1. Problem Statement: The facility failed to ensure residents or residents representatives received a written transfer notice for resident #'s: 1,19,56,73, and 173. 2. Corrective Action: DON/Designee will educate 100% of nurses on Requirements before a	

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F 623	Continued From page 6 his/her baseline, had a left leg which was red and hot with a "red line," was running a fever of 101.7 degrees Fahrenheit, and had wheezing. Further review showed the nurse sent the resident to the hospital. The following concerns were identified: a. Review of the medical record showed no evidence a written transfer/discharge notice was provided to the resident or resident's representative. 2 Review of the medical record showed resident #19 was transferred to the hospital on 4/12/22 for an acute change of condition and readmitted to the facility on 4/26/22; transferred to the hospital on 5/7/22 for an acute change of condition and readmitted to the facility on 5/12/22; and transferred to the hospital on 6/10/22 for an acute change of condition and readmitted to the facility on 7/8/22. Further review showed no evidence the facility issued a written transfer notice to the resident. 3. Review of a progress note dated 6/23/22 and timed 10:59 PM showed resident #56 had "nausea, vomiting, and diarrhea," was weak, and fatigued easily. The resident was sent to the hospital for evaluation and treatment. Review of a progress note dated 6/28/22 and timed 9:37 PM showed "no concerning issues after being re-admitted in previous shift..." The following concerns were identified: a. Review of the medical record showed no evidence a written transfer/discharge notice was provided to the resident or resident's representative. 4. Review of the medical record showed resident #73 was transferred to the hospital on 6/2/22 for an acute change of condition. Further review	F 623	transfer/discharge by 8/17/2022. 3. Identification of others: All residents could be affected by the deficient practice. 4. Systemic Changes: DON/Designee will Educate all current nurses by 8/17/2022. DON/Designee will educate new nurses on the Transfer/Discharge requirement process during orientation. " Notice before transfer. Before a facility transfers or discharges a resident, the facility must-(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and(iii) Include in the notice the items described in paragraph (c)(5) of this section. " Timing of the notice.(i) Except as specified in paragraphs (c)(4)(ii)and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.(ii) Notice must be made as soon as practicable before transfer or discharge when-(A) The safety of individuals in the facility would be	

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F 623	Continued From page 7 showed no evidence the facility issued a written transfer notice to the resident or the resident's representative. 5. Review of the medical record showed resident #173 was transferred to the hospital on 5/23/22 for an acute change of condition and readmitted to the facility on 5/29/22. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative. 6. Interview with the DON on 7/27/22 at 5:01 PM revealed the written transfer/discharge notices were not provided to the resident or resident representatives. 7. Review of the "Transfers and Discharges" policy and procedure, last revised 6/3/20, showed "...Before a facility transfers or discharges a resident, the facility must---(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman..."	F 623	endangered under paragraph (c)(1)(i)(C) ofF623If " B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or(E) A resident has not resided in the facility for30 days.483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: " (ii) The effective date of transfer or discharge. " (iii) The location to which the resident is transferred or discharged. " (iv) A statement of the resident's appeal rights, including the name, address (mailing and email),and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; " v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;(" vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	

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F 623	Continued From page 8	F 623	developmental disabilities established underpart C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000. " (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. " 483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at 483.70(l). 5. Ongoing: DON/Designee will audit charts of residents that have transferred/discharged out of facility weekly x 4 weeks then monthly x 2 months. Audits will be reviewed monthly in QAPI for up to 6 months or until IDT determines that the goals have been met.	

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F 623	Continued From page 9	F 623	DON/Designee will continue to educate nurses until 100% compliance	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. 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 residents or residents' representatives	F 625	1. Problem statement: The facility failed to ensure residents or resident□s representatives received	9/21/22

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F 625	Continued From page 10 received written information on the bed-hold policy for 5 of 5 sample residents (#1, #19, #56, #73, #173) reviewed for hospitalization. The findings were: 1. Review of a progress dated 7/16/22 and timed 5:06 PM showed resident #1 had not been at his/her baseline, had a left leg which was red and hot with a "red line," was running a fever of 101.7 degrees Fahrenheit, and had wheezing. Further review showed the nurse sent the resident to the hospital. The following concerns were identified: a. Review of the medical record showed no evidence written bed-hold policy information was provided to the resident or resident's representative on the day of hospital admission. 2. Review of the medical record showed resident #19 was transferred to the hospital on 4/12/22 for an acute change of condition and readmitted to the facility on 4/26/22; transferred to the hospital on 5/7/22 for an acute change of condition and readmitted to the facility on 5/12/22; and transferred to the hospital on 6/10/22 for an acute change of condition and readmitted to the facility on 7/8/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalizations. 3. Review of a progress note dated 6/23/22 and timed 10:59 PM showed resident #56 had "nausea, vomiting, and diarrhea," was weak, and fatigued easily. The resident was sent to the hospital for evaluation and treatment. Review of a progress note dated 6/28/22 and timed 9:37 PM showed "no concerning issues after being re-admitted in previous shift..." The following concerns were identified:	F 625	written information on the bed-hold policy for 5 of 5 sample residents□ #□s: 1, 19, 56, 73, 173. 2. Corrective Action: DON/Designee will educate 100% of nurses on Bed hold Policy requirements by 8/17/2022. 3. Identification of others: All residents could be affected by the deficient practice. 4. Systemic Changes: DON/Designee educated on staff on Bed hold process and ensure compliance with 483.15(d)(1)(2). DON/Designee will educate new nurses on the Bed Hold process during orientation. 5. Ongoing: DON/Designee will audit charts of residents that have transferred/discharged out of facility to ensure resident was given a copy of the Bed Hold policy weekly x 4 weeks then monthly x 2 months. Audits will be reviewed monthly in QAPI for up to 6 months or until IDT determines that the goals have been met. DON/Designee will continue to educate nurses until 100% compliance	

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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 625	Continued From page 11 a. Review of the medical record showed no evidence written bed-hold policy information was provided to the resident or resident's representative on the day of hospital admission. 4. Review of the medical record showed resident #73 was transferred to the hospital for an acute change of condition on 6/2/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 5. Review of the medical record showed resident #173 was transferred to the hospital on 5/23/22 for an acute change of condition and readmitted to the facility on 5/29/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 6. Interview with the DON on 7/27/22 at 5:01 PM revealed written bed-hold policy information was not provided to the residents or residents' representatives. 7. Review of the "Bedhold/Reservation of Room" policy, effective 5/2/19, showed "...Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy..."	F 625		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		9/21/22

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	535049	A. BUILDING _____ B. WING _____	C 07/28/2022

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F 732	Continued From page 12 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the daily nurse staffing	F 732	IDR in Attachments:	

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F 732	Continued From page 13 information in a prominent location; readily accessible to residents and visitors, and in a clear and readable format. In addition the facility failed to include the daily census on the daily staff postings. The census was 86. The findings were: 1. Observation on 7/27/22 at 2:37 PM showed the daily nurse staffing information was located in the lobby area behind the receptionist's desk which was enclosed with a plastic infection control shield. The daily nurse posting was attached to the wall 5 feet from the floor. The posting consisted of an 8.5 by 11 inch page behind a plastic protector on which green numbers were entered with an erasable marker. The posting was not legible. 2. Interview with receptionist #1 on 7/27/22 at 2:37 PM confirmed the information on the daily nurse staff posting was not legible or in a location easily accessible to residents or visitors. 3. Review of the "Nursing Staff Directly Responsible For Resident Care" postings for the dates of 7/8/22 through 7/26/22 showed the daily census was not included on the posting. 4. Interview with the DON on 7/27/22 at 2:55 PM revealed the facility was not aware the census information was required on the daily postings.	F 732	1. Problem Statement: The facility failed to post the daily nurse staffing information in a prominent location, readily accessible to residents and visitors, and in a clear and readable format. In addition, the facility failed to include the daily census on the daily staff postings. 2. Corrective Action: ED ordered new sign after survey. Sign was then placed on 8/9/2022 in an area that is clear and readily accessible to residents and visitors. Education done with Nursing Staff Directly Responsible For Resident Care postings, on 8/17/2022 to include daily census on the daily census board. 3. Identification of others: All residents and visitors could be affected by the deficient practice. 4. Systemic changes: Sign ordered, DON/Designee did education with person/s responsible for updating posting to include census. 5. Ongoing: DON/ED/Designee will audit the Nurse staffing board daily x 30 days then randomly x 90 days to ensure that it is complete and includes census.	
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	F 758		9/21/22

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F 758	Continued From page 14	F 758		

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

§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.

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F 758	Continued From page 15 §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 review of policy and procedure, the facility failed to ensure appropriate behavior monitoring and interventions were in place for 2 of 5 sample residents (#1, #34) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated 7/13/22 showed resident #1 had diagnoses which included Parkinson's disease, non-Alzheimer's dementia, anxiety disorder, and depression. Review of the physician orders for July 2022 showed the resident received amitriptyline hydrochloride (antidepressant) 20 mg (milligrams) by mouth at bedtime, escitalopram oxalate (antidepressant) 20 mg by mouth daily, and quetiapine fumarate (antipsychotic) 100 mg by mouth at bedtime. The following concerns were identified: a. Review of the behavior monitoring sheet provided by the facility on 7/28/22 showed a target symptom/behavior of physical aggression for amitriptyline and visual hallucinations for quetiapine; however, there was no identified target symptom or behavior for the use of escitalopram. b. Review of the "behaviors" care plan last revised on 7/21/22 showed the resident experienced exit seeking behaviors, physical aggression towards staff, a history of feeling confused, and hallucinations. Further review	F 758	1. Problem Statement: The facility failed to ensure appropriate behavior monitoring and interventions were in place for resident #1 and #34. 2. Corrective Action: Behavior monitoring and interventions were scheduled in PCC tasks for resident #1 and 34. 3. Identification of Others: Any resident who receives a Psychotropic medication could be affected by the deficient practice. DON/Designee identified all residents in facility that receive a psychotropic medication, Behavior monitoring and interventions was scheduled in PCC tasks and if PRN psychotropic medication supplemental behavior documentation will be scheduled for Nurses. 4. Systemic Changes: DON/Designee implemented a new process for Monitoring behaviors and Interventions in PCC Tasks and supplemental documentation for PRN psychotropic medications. DON/Designee will educate/train all nurses and cna□s on new process for	

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F 758	Continued From page 16 showed no specific target symptom identified for the use of escitalopram and no non-pharmacological interventions identified for identified behaviors. 2. Review of the quarterly MDS assessment dated 6/8/22 showed resident #34 had diagnoses which included anxiety disorder and depression. Review of the physician orders for July 2022 showed the resident received lorazepam (antianxiety) 0.5 mg by mouth daily at bedtime, escitalopram oxalate (antidepressant) 15 mg by mouth twice per day, and doxepin hydrochloride (antidepressant) 3 mg by mouth daily at bedtime. The following concerns were identified: a. Review of the "psychotropic RX [prescription]" care plan last revised on 6/14/22 showed the resident suffered from chronic anxiety, depression with recent exacerbation due to loss of family member, and friend's daughter with cancer. Further review showed there were no non-pharmacological interventions identified. 3. Interview with the social services director on 7/28/22 at 8:45 AM confirmed there were no identified target symptom/behaviors identified for some of the medications and revealed it would be difficult to identify the effectiveness of medications without knowing the target symptom/behaviors for each medication. 4. Review of the policy titled "Behavioral Health Management" last revised 8/2/21 showed "...Procedure...3. Initiate Behavior Monitoring, Behavior Management Care Plan, and Kardex as indicated by assessment findings, use of psychoactive medications, resident/responsible party conversations, and observations...The facility must provide necessary behavioral health	F 758	Monitoring Behaviors and Interventions by 8/3/2022. 5. Ongoing: SSD/Designee will pull the Behavior monitoring and Intervention report 5 days a week to ensure appropriate documentation of behaviors and interventions. SSD/Designee will discuss/huddle any new behaviors or unresolved behaviors after interventions in Grand rounds with Nursing and IDT.	

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F 758	Continued From page 17 care and services which include:...Ensuring that pharmacological interventions are only used when nonpharmacological interventions are ineffective or when clinically indicated..."	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the 2017 U.S. Public Health Service Food Code, and policy and procedure review, the facility failed to ensure sanitary meal service during 1 of 2 meal observations. The census was 86. The findings were: 1. Observation on 7/27/22 at 11:34 AM showed dietary aide #1 used his right hand to grab the front of his mask and pull it away from his face to	F 812	1. Problem Statement: Facility failed to ensure sanitary meal service during 1 of 2 meal observations. The census was 86. 2. Corrective Action: All dietary staff were educated by the Division RDN on 7/27/2022, focusing on	9/21/22

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F 812	Continued From page 18 talk with another staff member. The dietary aide returned the mask to his face and used the same hand to grab a plate from the plate warmer. At that time, the dietary aide's thumb wrapped over the top of the plate and touched the food surface of the plate. No hand hygiene was performed. 2. Observation on 7/27/22 at 11:35 AM showed the dietary aide #1 grabbed the front of his face mask, with his right hand, and pulled it down to position it below his chin. At that time, he left the mask under his chin and continue to place food on trays. No hand hygiene was performed. 3. Observation on 7/27/22 at 11:36 AM dietary aide #1 used his right hand to grab the front of his mask and pull it away from his face and returned the mask to his face, covering his mouth and nose. The dietary aide used the same hand to grab a plate from the plate warmer. At that time, the dietary aide's thumb wrapped over the top of the plate and touched the food surface of the plate. No hand hygiene was performed. 4. Observation on 7/27/22 at 11:39 AM showed dietary aide #1 grabbed 2 plates from the plate warmer with his right hand. At that time, his hand touched the center of the plate, which he then placed pizza on. Continued observation showed the dietary aide left the service line, opened the door to the walk-in cooler with his right hand, obtained a salad, placed it on a plate, and pushed a cart into the walk-in cooler. The dietary aid returned to the service line without performing hand hygiene. 5. Observation on 7/27/22 at 11:43 AM showed dietary aide #1 went to the walk-in cooler and opened the door with his right hand, returned to	F 812	distributing food safely, infection control principles and hand hygiene. In- service included, but was not limited to: hand hygiene, how to appropriately wear a mask, including removing when tasting foods and putting back on without cross contamination, the appropriate handling of cups, plates, bowls, and no bare handling of food. Executive Director/DON completed individual formal education with Dietary aide #1 on 8/17/2022 to reinforce the importance of good hand hygiene, no bare handling of foods and other food safety principles to minimize cross contamination and the consequences associated with not following food safety guidelines, in particular for high risk residents. 3. Identification of others: All residents and staff who eat in the facility are identified to be at risk of the alleged deficient practice. 4. Systemic Changes: All high usage food items will be placed on or near the line prior to service to minimize leaving the serving line and minimizing the risk for cross contamination. All desserts and salads will be placed on or within proximity from the line for easy access to minimize having to go to other food storage area. Prep cook will be responsible for obtaining additional food items requested at meal times so the cook and/or server do not have to leave	

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F 812	Continued From page 19 the service line with items obtained from the cooler, left the service line, and opened the walk-in cooler with his left hand. The dietary aide obtained some bowls of food, went to the microwave, opened the microwave door with his right hand, and placed one of the bowls in the microwave. The dietary aide returned to the service line with packages of crackers in his right hand, and placed the crackers on a resident tray. The dietary aide returned to the microwave, opened the door with his right hand, removed the bowl from the microwave, and placed another bowl in the microwave. No hand hygiene was performed. 6. Observation on 7/27/22 at 11:51 AM showed dietary aide #1 grabbed 2 plates from warmer, touching the food surface area of the top plate with his right thumb, and placed pizza on the plate. The dietary aide cut one slice of pizza with a fork and knife, during which time his right hand came in contact with the pizza. The dietary aide walked over to an area of the service line where there were breadsticks, obtained two breadsticks and placed them on the plate. The dietary aide returned to the other plate, placed a slice of pizza on the plate, and with an ungloved right hand, grabbed one of the breadsticks from the first plate, and placed it next to the pizza on the second plate. No hand hygiene was performed. 7. Interview with dietitian #1, dietitian #2, and the dietary manager on 7/27/22 at 12:24 PM revealed hand hygiene should be performed when staff changed tasks or picked items up off the floor. Further interview confirmed staff should not touch food or food surfaces with hands and hand hygiene should be performed after touching items like the external portion of a face mask. Further	F 812	the line, minimizing potential for cross contamination Signs were posted throughout the kitchen as a friendly reminder on appropriate mask wearing for foodservice professionals 5. Ongoing Monitoring: The dietary manager or designee will audit (see attached) 3 x per week to ensure foods are served and distributed safely, masks are worn appropriately and no bare handling of foods. Audits will be brought to the monthly QAPI meeting, reviewed and continue until QAPI team determines sustained compliance.	

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F 812	Continued From page 20	F 812		

interview revealed it was not facility policy to wash hands each time a staff member left the service line, as it would slow meal service and staff should use serving utensils during meal service which would prevent them from contaminating food.

8. Review of the policy titled "Personal Habits and Infection Control" provided by the facility on 7/28/22 at 9:50 AM showed "...Required Personal Practices....Wash your hands properly and frequently...Personal Practices to Avoid...Unsanitary personal practices, such as scratching the head, placing the fingers in or about the mouth or nose, sneezing or coughing in the area of food or clean dishes, or incorrectly sampling food can contaminate food and spread foodborne illness. Careless handling and unnecessary contact with soiled surfaces of dishes, glasses, cups, and tableware or with soiled napkins may expose associates to needless health hazards...Wash your hands thoroughly after completing each task to protect yourself and avoid contaminating the items you handle next...Good Habits to Practice....keep your hands off the eating surfaces or plates...Use tongs, a scoop, or a spoodle when serving food. Do not use your hands or contaminated gloves..."

9. Review of the facility policy titled "Sanitary Food Handling" provided by the facility on 7/28/22 at 9:50 AM showed "....Hands should always be washed upon entering the kitchen and immediately after touching your head, hair, or face...When food is served, a separate serving utensil should be used for each item. Fingers and hands should not be used for serving...

10. According to Food Code 2017, U.S. Public

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F 812	Continued From page 21 Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812		