STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

(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 1/9/23 to 1/12/23. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse TAR: Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		2/11/23

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

Electronically Signed | 02/01/2023

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

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F 609	Continued From page 1 for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, elder representative and staff interview, and policy and procedure review, the facility failed to ensure injuries of unknown origin were reported for 1 of 6 sample elders (#16) reviewed for abuse. The findings were: 1. Review of the quarterly MDS assessment dated 11/7/22 showed elder #16 had a BIMS score of 3 out 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's dementia, cerebral vascular accident or transient ischemic attack, and Parkinson's disease. Further review showed the elder required extensive physical assistance of 1 person for bed mobility, transfers, dressing, eating, locomotion on and off the unit, eating, toileting, and bathing, and was totally dependent on staff for personal hygiene. Review of the elder's communication care plan last revised on 6/22/21 showed "Elder has difficulty making self-understood r/t [related to] occasionally having inability to speak intelligible words." The following concerns were identified: a. Interview with the elder's representative on 1/10/23 at 1:50 PM revealed the elder's "previous	F 609	1) Corrective action for all residents will be free from Abuse, Misappropriation of residents property, and exploitation. This includes, but is not limited to freedom from corporal punishment, involuntary seclusion and any physical, or chemical restraint, not required to treat the residents medical symptoms. 2) Corrective action for resident #16: All staff trained on resident rights. A safe interview was conducted on 12/4/2022 and 12/30/22. 3) Action to prevent other residents from being affected include: Quarterly safe interviews on MDS rotation. Social Services provides frequent meetings with all residents. 4) Corrective action includes: All staff who have been scheduled during the time of injury of unknown origin were re-educated on the Abuse/reporting injury of unknown origin etc in a timely manner. All staff will be re-educated on a quarterly basis. All staff will be educated by 2/11/2023. 5) Corrective actions include: All staff who have been scheduled were educated if the	

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F 609	Continued From page 2 roommate broke [his/her] hand" during an elder to elder altercation. b. Review of a progress note dated 12/11/22 and timed 9:01 PM showed staff heard a noise coming from the elder's room. Upon entry, staff observed elder #16 and being grabbed by his/her roommate on his/her arms. Staff attempted to get the roommate to release the elder and when s/he did, the roommate pushed elder #16. Following the incident, staff identified a "skin tear" to the elder's left arm; however, no additional injuries were identified. c. Review of a progress note dated 12/12/22 and timed 8:42 PM showed the elder began to cry at dinner and was unable to verbalize what was wrong. At that time, staff identified a bruise and swelling to the elder's left index finger and left thumb. d. Review of a progress note dated 12/13/22 and timed 2:33 PM showed the elder's left index finger remained swollen and discolored and the elder was transferred to the emergency department. At that time, a fracture to the elder's left index finger which was "slightly displaced" was identified and a splint was applied. e. Review of a HLS incident report from the facility dated 12/12/22 showed an elder to elder altercation was reported; however, there was no injury to the elder's left index finger identified. Further review of incidents reported to HLS showed no evidence the left finger fracture was reported. f. Interview with the social services manager on 1/12/23 at 9:08 AM confirmed the elder had an incident with his/her roommate the day prior to the identification of the finger fracture; however, it was revealed the DON did not feel the fracture was related to the altercation. Further interview revealed a new incident report and investigation	F 609	alleged perpetrator is a staff member, the staff member will be suspended immediately during an investigation. All staff will be educated by 2/11/2023. 6) Corrective action plan: State Incident opened 1/13/2023 for injury on unknown origin for incident regarding resident #16, for incident on 12/12/2022. Incident was submitted with all information to support prior incident on 12/11/22 was unrelated due to the time frame between these two incidents. All staff to be trained on reporting incidents in a timely manner. 7) Corrective Action taken to prevent deficiency recurrence: Director of Nursing, Social Services, and or Administrator will report all alleged incidents, as required to local, state, federal agencies within two hours of incident. After conduction an extensive internal investigation, a written report of all investigation results will be submitted to the State within five days. A daily review of all residents during clinical meeting to ensure any incidents have been identified, reported, submitted, investigated, and investigation submission has been properly completed. Monitoring: All incidents will be reported to QA for review weekly for 12 weeks, then quarterly there after. QA will review all incidents with QAPI team at quarterly meetings as part of the ongoing agenda.	

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F 609	Continued From page 3 should have been performed due to the injury being of unknown origin. She confirmed the facility was unsure how the finger fracture occurred. g. Interview with the physical therapist/quality assurance manager on 1/12/23 at 10:41 AM confirmed the facility should have investigated and reported the finger fracture as an injury of unknown origin. 2. Review of the policy titled "Abuse/Neglect/Misappropriation/Exploitation" dated 8/28/22 showed "Identification...All staff will be observant for any resident or staff conditions that might be indicative or predictive of potential abuse and/or neglect, such as suspicious bruising, withdrawn behaviors, stress, change in behaviors, etc. All observations of suspected abuse should be immediately reported to your supervisor or the administrator. All "injuries of unknown origin" will be reviewed to determine if thy meet criteria for being reported. All "injuries of unknown origin" that meet criteria will be investigated that includes an abuse investigation...Investigation...All allegations of abuse, exploitation, and/or neglect will be investigated in accordance with state and federal laws. All unusual occurrences need to be reported to immediate supervisor for investigation..."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		2/11/23

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F 610	Continued From page 4 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, elder representative and staff interview, and policy and procedure review, the facility failed to ensure injuries of unknown origin were investigated for 1 of 6 sample elders (#16) reviewed for abuse. The findings were: 1. Review of the quarterly MDS assessment dated 11/7/22 showed elder #16 had a BIMS score of 3 out 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's dementia, cerebral vascular accident or transient ischemic attack, and Parkinson's disease. Further review showed the elder required extensive physical assistance of 1 person for bed mobility, transfers, dressing, eating, locomotion on and off the unit, eating, toileting, and bathing, and was totally dependent on staff for personal hygiene. Review of the elder's communication care plan last revised on 6/22/21 showed "Elder has difficulty making self-understood r/t [related to] occasionally having inability to speak intelligible words." The following concerns were identified:	F 610	1) Corrective action includes: Establish Abuse Guidance Audit form to ensure complete dates, times, interviews of all staff and residents are documented and complete. Corrective action will be complete by 2/11/2023. Social Services, Director of Nursing, or Administrator will initiate an investigation of all injury of unknown origin. All staff who have been scheduled during the time of injury of unknown origin, as well as all others, were re-educated on the Abuse/reporting of injury of unknown origin policy and the importance of reporting any type of injury of unknown origin in a timely manner. In addition, the policy of reporting Injury of unknown origin has been amended to include procedures to include resident to resident altercations, and the steps to ensure each resident is free from injury or further altercation. 3)Corrective Action for resident #16: All staff educated on Resident Rights. A safe interview, to ensure each resident feels	

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F 610	Continued From page 5 a. Interview with the elder's representative on 1/10/23 at 1:50 PM revealed the elder's "previous roommate broke [his/her] hand" during an elder to elder altercation. b. Review of a progress note dated 12/11/22 and timed 9:01 PM showed staff heard a noise coming from the elder's room. Upon entry, staff observed elder #16 being grabbed by his/her roommate on his/her arms. Staff attempted to get the roommate to release the elder and when s/he did, the roommate pushed elder #16. Following the incident, staff identified a "skin tear" to the elder's left arm; however, no additional injuries were identified. c. Review of a progress note dated 12/12/22 and timed 8:42 PM showed the elder began to cry at dinner and was unable to verbalize what was wrong. At that time, staff identified a bruise and swelling to the elder's left index finger and left thumb. d. Review of a progress note dated 12/13/22 and timed 2:33 PM showed the elder's left index finger remained swollen and discolored and the elder was transferred to the emergency department. At that time, a fracture to the elder's left index finger which was "slightly displaced" was identified and a splint was applied. Further review showed no evidence the finger fracture was investigated or source of injury was identified. e. Review of a HLS incident report from the facility dated 12/12/22 showed an elder to elder altercation was reported; however, there was no injury to the elder's left index finger identified. Further review of incidents reported to HLS showed no evidence the left finger fracture was investigated. f. Interview with the social services manager on 1/12/23 at 9:08 AM confirmed the elder had an	F 610	safe, will occur PRN as investigations occur, as well as quarterly on the MDS rotation schedule. Resident #16 was moved from assigned room into another room after altercation with roommate, one day prior of injury of unknown origin. Social Services provides frequent meetings with residents outside of incident investigations. 4) Corrective action to prevent other residents from being affected include: A safety interview was completed 12/30/22 for resident #16. Every resident will have a safety interview completed PRN during investigative purposes, and quarterly on their MDS rotation schedule. 5) Monitoring: ID team will review each resident chart daily during clinical meeting to ensure all injury of unknown origin have been reported and investigated, and that a safety interview is completed in accordance to the findings. QA will monitor completion of safety interviews monthly, and as needed per allegation. QA will audit the Abuse guidance Audit form and safe interviews throughout each investigation process to ensure a thorough investigation. Review of all incident reporting, as well as safety interviews will be part of the quarterly QAPI team meetings agenda.	

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F 610	Continued From page 6 incident with his/her roommate the day prior to the identification of the finger fracture; however, it was revealed the DON did not feel the fracture was related to the altercation. Further interview revealed a new incident report and investigation should have been performed due to the injury being of unknown origin. She confirmed the facility was unsure how the finger fracture occurred. g. Interview with the physical therapist/quality assurance manager on 1/12/23 at 10:41 AM confirmed the facility should have investigated and reported the finger fracture as an injury of unknown origin. 2. Review of the policy titled "Abuse/Neglect/Misappropriation/Exploitation" dated 8/28/22 showed "Identification...All staff will be observant for any resident or staff conditions that might be indicative or predictive of potential abuse and/or neglect, such as suspicious bruising, withdrawn behaviors, stress, change in behaviors, etc. All observations of suspected abuse should be immediately reported to your supervisor or the administrator. All "injuries of unknown origin" will be reviewed to determine if they meet criteria for being reported. All "injuries of unknown origin" that meet criteria will be investigated that includes an abuse investigation...Investigation...All allegations of abuse, exploitation, and/or neglect will be investigated in accordance with state and federal laws. All unusual occurrences need to be reported to immediate supervisor for investigation..."	F 610		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)	F 637		2/11/23

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F 637	Continued From page 7 §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the CMS RAI manual version 3.0, the facility failed to ensure a significant change assessment was completed as indicated for 1 of 12 sample elders (#22). The findings were: 1. Review of the annual MDS assessment dated 7/4/22 showed elder #22 had a BIMS score of 13 out of 15, which indicate the elder was cognitively intact, and had diagnoses which included non-Alzheimer's dementia, Parkinson's disease, spinal stenosis, and a history of falls. The elder required extensive physical assistance of 1 person to walk in his/her room and limited physical assistance of 1 person for toilet use. Further review showed for balance during transitions and walking, the elder was "not steady, only able to stabilize with human assistance" while moving from seated to standing position and walking (with assistive device if used), "not steady, but able to stabilize without human assistance" during surface to surface transfer (transfer between bed and chair or wheelchair),	F 637	1) Corrective Action for resident #22: A change of condition MDS to reflect development of contractures was created, completed and conformation of accepted submission 1/31/23. A restorative nursing program to address contractures and mobility was implemented 1/27/2023. 2) Corrective Action taken to prevent deficiency: IDT to conduct resident census chart review during daily clinical meeting to ensure any resident status changes are documented in the nurse 'Alert Charting' record for nursing and MDS to review and MDS to generate a significant change assessment that identifies change in condition. 3) Identification of others: Other residents could be negatively impacted if they endured a significant change and did not receive the proper interventions necessary to support management, intervention, resolution or impacts on physical and mental well-being. 4) System Measures: MDS, nursing staff,	

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F 637	Continued From page 8 had no upper or lower extremity functional limitation in range of motion, and received no restorative therapy. The following concerns were identified: a. Observation on 1/11/23 at 2:23 PM showed the elder had visible contractures, with both feet rolling inward at the ankle. b. Review of the quarterly MDS assessment dated 10/3/22 showed the elder had diagnoses which included right ankle contracture and walk in room was coded as activity did not occur. For balance during transitions and walking the elder was coded "activity did not occur" for walking (without assistive device if used) and "not steady, only able to stabilize with human assistance" for surface-to-surface transfer (transfer between bed and chair or wheelchair). Further review showed the elder's lower extremity functional limitation in range of motion was coded as "impairment on both sides" and the elder received passive range of motion restorative nursing programs on 3 out 7 days during the look-back period. c. Interview with the physical therapist/quality assurance manager on 1/12/23 on 11:38 AM revealed a significant change MDS assessment should have been performed when the elder developed contractures. 2. Review of the CMS "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.17.1" last revised October 2019 showed "...A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or	F 637	and all members of the IDT re-educated on 'Alert Charting' and documentation, for change in status to include when necessary to generate a significant change assessment. 5) Monitoring: Director of Nursing, IDT clinical team, and MDS will audit 'Alert Charting' daily during clinical morning meetings for 12 weeks to ensure a significant change MDS is not required. All audits for 'Alert Charting' will be turned into QA to be presented during quarterly QAPI meeting to ensure significant change MDS are being generated according to CMS RAI instrument. This review will be included on the QAPI meeting agenda to occur quarterly thereafter the initial 12 weeks.	

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F 637	Continued From page 9 revision of the care plan..."	F 637		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on elder representative and staff interview, and medical record review, the facility failed to ensure elders or elders' representative were included in care plan development for 1 of 12 sample elders (#16). The findings were:	F 657	1) Corrective Action taken for resident #16: A care conference notice will be mailed out 10 days prior to next care conference due date. The letter will include a self addressed postage paid	2/11/23

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F 657	Continued From page 10 1. Interview with the elder #16's representative on 1/10/23 at 1:53 PM revealed she would like to participate in the care plan meetings, and she had not been invited or participated in a care plan meeting "for months." 2. Review of the "Case Management Case Conference Form" dated 12/27/22 showed neither elder #16 or the elder's representative participated in the care conference. Further review showed the facility attempted to contact the representative by phone on the day of the care conference; however, they were unable to reach her. 3. Interview with the social services manager on 1/11/23 at 4:46 PM revealed the facility "recently made a bunch of changes" and as a result, the elder's representative was not invited or notified of the care conference meeting prior to the day the meeting was held.	F 657	envelope to return a response of invitation back to the facility free of charge. In addition, a reminder phone communication will be made, and documented, 3 days prior to care conference due date. A follow-up phone communication will be implemented the day after the care conference for representatives who could not attend the care conference in person or whomever was not able to be reached by phone communication prior to care conference. 2) Corrective Action taken to prevent deficiency recurrence: The facility will ensure new admissions will have either in person, or phone communication care conference within 7 days of admit, and one every 3 months in rotation with residents MDS. An invitation letter will be sent out 10 days prior to care conference, and again 3 days prior to conference. All attempts of invitation will be documented in the resident record. 3) Identification of others: Other representatives and residents could be affected if prior notification of care conference is not made into policy. The resident and or representative do not get to express concerns or give input into residents care if they are not included in their individualized care conference. 4) Monitoring: QA and Social Services will audit care conference invitations weekly x12 weeks via Excel tracking sheet, to include dates, person invited, and resident involvement upon admission and every care conference quarterly at MDS rotation to ensure proper invitation and attendance. Audits will be shared with	

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F 657	Continued From page 11	F 657	QAPI team during quarterly QAPI meetings. Audits will be ongoing via spread sheet to ensure compliance.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, elder and staff interview, medical record review, and policy and procedure review, the facility failed to ensure elders received services to maintain range of motion for 2 of 4 sample elders (#4, #22) reviewed for range of motion. The findings were: 1. Review of the annual MDS assessment dated 7/4/22 showed elder #22 had a BIMS score of 13 out of 15, which indicate the elder was cognitively intact, and had diagnoses which included non-Alzheimer's dementia, Parkinson's disease,	F 688	1) Corrective Action taken for resident #22: A restorative nursing program for bilateral lower extremity active range of motion, as well as massage and passive range of motion to bilateral ankles/feet was implemented 1/27/2023. Care plan was updated to include restorative nursing program with measurable objective for participation included. Corrective Action taken for resident #4: A restorative nursing program for passive range of motion to bilateral upper and	2/11/23

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F 688	Continued From page 12 spinal stenosis, and a history of falls. The elder required extensive physical assistance of 1 person to walk in his/her room and limited physical assistance of 1 person for toilet use. Further review showed for balance during transitions and walking, the elder was "not steady, only able to stabilize with human assistance" while moving from seated to standing position and walking (with assistive device if used), "not steady, but able to stabilize without human assistance" during surface to surface transfer (transfer between bed and chair or wheelchair), had no upper or lower extremity functional limitation in range of motion, and received no restorative therapy. The following concerns were identified: a. Observation on 1/11/23 at 2:23 PM showed the elder had visible contractures, with his her feet rolling inward at the ankle, on his/her bilateral lower extremities. b. Review of the quarterly MDS assessment dated 10/3/22 showed the elder had diagnoses which included right ankle contracture and walk in room was coded as "activity did not occur". For balance during transitions and walking the elder was coded "activity did not occur" for walking (without assistive device if used) and "not steady, only able to stabilize with human assistance" for surface-to-surface transfer (transfer between bed and chair or wheelchair). Further review showed the elder's lower extremity functional limitation in range of motion was coded as "impairment on both sides" and the elder received passive range of motion restorative nursing programs on 3 out of 7 calendar days during the look-back period. c. Review of the restorative program documentation for January 2023, December 2022, November 2022, and October 2022 showed the elder received restorative services on	F 688	lower extremity, as well as gentle massage to neck and shoulders was implemented 1/27/2023. Care plan was updated to include restorative nursing program with measurable objective for participation included. 2) Corrective Action taken to prevent deficiency recurrence: Any resident with OT/PT orders upon admission will be placed on a restorative nursing program that addresses mobility goals. Also upon admission, Social Services interviews the resident with the Resident Admission/Discharge Checklist and Summary to establish what mobility goals each resident would like to set for themselves. A restorative nursing program will be established according to their needs. A referral for restorative nursing will be forwarded to QA for establishment of program, and staff training for programming will ensue. A quarterly review of restorative programming will be addressed during quarterly care conference for any updates or changes to restorative programming according to the goals achieved or not, and as to what the resident would like to happen. Restorative nursing education, including documentation training will be completed by 2/11/2023. All residents restorative programs have been added to the mini care plan that is used by the CNA's to ensure they are familiar with the individualized programs. 3) Identification of others: Other residents could be affected if they have mobility, ADL or other needs that should be addressed by an individualized restorative	

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F 688	Continued From page 13 10/3/22, 10/4/22, and 10/5/22. The facility was unable to provide additional evidence the restorative program was provided during the time frame. 2. Review of the quarterly MDS assessment dated 11/1/22 showed elder #4 had a BIMS score of 15 out of 15, which indicated the s/he was cognitively intact, and had diagnoses which included depression and multiple sclerosis. Further review showed the elder was totally dependent on 2 or more staff for bed mobility, transfers, and dressing, was totally dependent on 1 staff member for locomotion on and off the unit, eating, personal hygiene, and bathing, had functional limitation in range of motion to bilateral upper and lower extremities, and was coded as having received passive range of motion restorative nursing programs on 6 out of 7 calendar days during the look-back period. Review of the "ADL Functional/Rehabilitation Potential" care plan last revised on 5/19/17 showed the elder "...requires passive range of motion to bilateral upper and lower extremities as well as neck during restorative nursing..." The following concerns were identified: a. Interview with the elder on 1/10/23 at 11:01 AM revealed the facility did not have a restorative CNA and restorative programs were not being performed. Observation at that time showed the elder was seated in a wheelchair with a blow bell (device elders can use to call nursing staff by blowing into a tube, due to not have ability to use arms and hands) for his/her call light. Further interview revealed s/he was not physically capable of using a call light or repositioning him/her self. b. Review of the restorative program documentation for January 2023, December	F 688	nursing program, and they do not receive the services that could improve their psychosocial well-being, mobility, and support their their optimal level of independence. 4) Monitoring: QA to audit restorative programming compliance weekly for 12 weeks, then quarterly thereafter. ID team will review all Restorative nursing programs with resident and representative during quarterly care conference. QA will review Restorative nursing residents list with QAPI team at quarterly QAPI team meeting to ensure programming is carried out according to schedule and restorative staffing is adequate. Restorative programming will be included on QAPI meeting agenda.	

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F 688	Continued From page 14 2022, November 2022, and October 2022 showed the elder received restorative services on 10/3/22, 10/4/22, and 10/5/22. The facility was unable to provide additional evidence the restorative program was provided during the time frame. 3. Interview with the physical therapist/quality assurance manager on 1/12/23 at 8:35 AM revealed the facility had not had anyone performing restorative services since October due to staffing issues. Further interview revealed she believed floor staff was performing some range of motion exercises; however, there was no documentation the programs were being completed. 4. Review of the policy titled "Specialized Rehabilitation or Restorative Services Policy" provided by the facility on 1/12/23 showed "...Provide the appropriate treatment and services outlined in the elder's plan of care to maintain, restore or improve the functional ability for the elder..."	F 688		
F 758 SS=E	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	F 758		2/11/23

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F 758	Continued From page 15 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. §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 staff interview, medical record review, and policy and procedure review, the facility failed	F 758	1) Corrective Action for resident #16: Order end date updated to 14 days and	

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F 758	Continued From page 16 to ensure PRN (as needed) orders for anti-psychotic medications were limited to 14 days for 2 of 5 sample elders (#16, #22) and failed to ensure appropriate behavior monitoring and interventions were in place for 3 of 5 sample elders (#2, #11, #16) reviewed for psychotropic medication use. The findings were: 1. Review of the significant change MDS assessment dated 11/16/22 showed elder #2 had a BIMS score of 14 out 15, which indicated the elder was cognitively intact, and diagnoses which included diabetes mellitus and thyroid disorder. Further review showed the elder received antidepressant medication on 7 of 7 days during the look back period. Review of the "Psychotropic Drug Use" care plan last revised on 2/6/20 showed the elder used psychotropic medications to assist with mood state and psychosocial well-being. Review of the physician orders showed the elder received citalopram (antidepressant) 20 milligrams (mg) by mouth daily for adjustment disorder with depressed mood and Trazadone (antidepressant) 25 mg by mouth at bedtime. The following concerns were identified: a. Review of the "Psychotropic Drug Use" care plan last revised 2/6/20 showed interventions which included "Administer medications as ordered. Monitor [elder's name] patterns of behavior and encourage [him/her] to join in activities. Further review showed no medication-specific target symptoms or non-pharmacological interventions were identified. b. Review of the medication administration record (MAR) and treatment administration record (TAR) for November 2022, December 2022, and January 2023 showed the facility had	F 758	PCP will review order at weekly rounds by 2/11/2023. Corrective Action for resident #22: Order end date updated to 14 days and PCP will review order at weekly rounds by 2/11/2023. Corrective action for resident #2: Interventions added in EMAR to document mood/symptoms each shift. Care plan was updated to include evaluation of mood/symptoms at quarterly review. Corrective Action for resident #11: Interventions added in EMAR to document mood/symptoms each shift. Care plan was undated to include evaluation of mood/symptoms at quarterly review. Corrective Action for resident #16: Interventions added in EMAR to document mood/symptoms each shift. Care plan was updated to include evaluation of mood/symptoms at quarterly review. Corrective Action for resident #16 and #22: Resident plan of care was reviewed and updated to include review of non-pharmacological interventions and documentation of actions taken prior to administration of PRN medication. AIMS was scheduled on the EMAR the 5th day of every 3rd month to be completed by nursing. Corrective action for resident #16 and #22: Educational in-service will be provided to clinical staff in regards to psychotropic medication rationale, GDRs process/duration of use, as well as proper documentation of interventions, symptoms	

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F 758	Continued From page 17 monitoring in place for depression and pain; however, there were no medication-specific target symptoms or non-pharmacological interventions identified. Further review showed no identified diagnosis for the use of Trazadone. 2. Review of the quarterly MDS assessment dated 11/21/22 for elder #11 had a BIMS score of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses which included Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intracranial injury without loss of consciousness, sequela. Review of the physician orders showed the elder received citalopram (antidepressant) 40 mg every day. The following concerns were identified: a. Review of the care plan showed no evidence the facility identified target symptoms specific to the use of antidepressants. b. Review of the MAR showed no evidence the facility was monitoring the elder for identified target symptoms specific to the use of antidepressants. 3. Review of the quarterly MDS assessment dated 11/7/22 showed elder #16 had a BIMS score of 3 out 15, which indicated severe cognitive impairment, and had diagnoses which included Alzheimer's disease, CVA or TIA, Parkinson's disease, and anxiety disorder. Further review showed the elder received antipsychotic medication on 7 of 7 days during the look back period. Review of the "Psychotropic Drug Use" care plan last revised on 3/22/21 showed the elder received antipsychotic medication related to Alzheimer's disease. Review of the physician orders showed the elder received aripiprazole (anti-psychotic) 5 mg by	F 758	treated, and behavior follow-up after administration of medication. In-service will completed by 2/11/2023. Preventative Measures/Monitoring: 1) All psychotropic medications will have a quarterly review scheduled when order is received, whether at admission or as a new order. 2) Quarterly in-service for clinical staff will provide education on psychotropic medications and required documentation, as well as proper documentation in the EMAR program upon hire. 3) Quarterly skills audit on medication order entry will be completed as assigned. 4) Quarterly audit on all psychotropic medications, GDR will be performed by clinical supervisor and documented in the psychotropic medication audit book. 5) All quarterly audits will be brought to Quality Assurance and reviewed at the quarterly QAPI meeting by the QAPI team. Quarterly review of mood/symptoms included in the Care plan will also be monitored by the quarterly QAPI team at the quarterly QAPI meeting, as well as on the quarterly MDS/care plan review. These reviews will be included on the ongoing quarterly QAPI meeting agenda going forward.	

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F 758	Continued From page 18	F 758		

mouth at bedtime for Alzheimer's disease and lorazepam (anti-anxiety) 1 mg by mouth twice per day as needed (PRN) for anxiety disorder due to known condition. The following concerns were identified:

a. Review of the "Psychotropic Drug Use" care plan last revised 3/22/21 showed interventions which included "AIMS every quarter...Monitor elder's behavior and response to medication...Quantitatively and objectively document/report the elder's behavior...Two staff in room while providing cares at this time due to recent allegations..." Further review showed no medication-specific target symptoms or non-pharmacological interventions were identified.

b. Review of the MAR and TAR for November 2022, December 2022, and January 2023 showed the facility had monitoring in place for "aphasia, delusions, confusion, mood swings, repetitive, and impulsive"; however, there were no medication-specific target symptoms or non-pharmacological interventions identified. Further review showed the PRN lorazepam was ordered on 7/26/22 and no stop date was indicated.

c. Review of a physician communication dated 8/4/22 showed the facility requested the physician continue lorazepam for 70 days (until 10/13/22) for effectiveness for treating anxiety which the physician signed. Further review showed no evidence a physician assessment or rationale was provided for extended use and there was no evidence an additional extension was performed following the 70 days.

4. Review of the quarterly MDS assessment dated 10/3/22 showed elder #22 had a BIMS score of 13 out 15, which indicated the elder was

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F 758	Continued From page 19	F 758		

cognitively intact, and had diagnoses which included non-Alzheimer's dementia, Parkinson's disease, and anxiety disorder due to known psychological condition. Further review showed the elder received antianxiety medication and antidepressant medication on 7 of 7 days during the look back period. Review of the "Psychosocial Well-Being" care plan last revised on 1/7/22 showed the elder used "...psychotropic medication to assist with mood state and psychosocial well-being. Staff will anticipate cares and perform as Elder will allow." Review of the physician orders showed the elder received lorazepam (anti-anxiety) 0.5 mg by mouth three times per day as needed (PRN) for anxiety disorder due to known condition. The following concerns were identified:

a. Review of a physician communication dated 8/11/22 showed the facility requested the physician continue the PRN lorazepam for 70 days (until 10/20/22) for effectiveness for treating anxiety which the physician signed. Further review showed no evidence a physician assessment or rationale was provided for extended use and there was no evidence an additional extension was performed following the 70 days.

5. Interview with the administrator, social services manager, and physical therapist/quality assurance manager on 1/12/23 at 8:47 AM revealed they were unsure how effectiveness of medication was determined and if a gradual dose reduction or risk benefit was needed. They confirmed no specific target symptoms or non-pharmacological interventions were identified for the elders. Further interview revealed a physician had not provided any additional rationale for continued long term use of the PRN

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F 758	Continued From page 20 psychotropic medications for elder #16 or elder #22. 6. Review of the policy titled "Psychotropic Drug Monitoring" dated 2/19/19 showed "...All PRN psychotropic medications will automatically have a 14 day limit and D/C [discontinue] must be entered into EMAR when initial order is entered into EMAR. Unless provider documents clear clinical rationale and documents a duration of PRN order. The new PRN psychotropic medication will have D/C dates that corresponds to the documented duration..."	F 758		