| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535025 | A. BUILDING _____ B. WING _____ | C 06/22/2023 |

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| **POLARIS REHABILITATION AND CARE CENTER** | **2700 E 12TH STREET CHEYENNE, WY 82001** |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by Healthcare Licensing and Surveys from 6/19/23 to 6/22/23. Also reviewed in the course of the survey was complaint intake WY00003605.<br><br>The following common abbreviations are used throughout this document:<br><br>BIMS: Brief Interview for Mental Status<br>CNA: Certified Nursing Assistant<br>DON: Director of Nursing<br>IDT: Interdisciplinary Team<br>LPN: Licensed Practical Nurse<br>MDS: Minimum Data Set<br>QAPI: Quality Assurance and Performance Improvement<br>RN: Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). | F 578 | | 7/13/23 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/16/2023 |

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 578 | Continued From page 1<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview, facility incident report review, and policy and procedure review, the facility failed to honor residents' right to refuse treatment for 1 of 18 sample residents (#57). The findings were:<br><br>1. Review of the significant change MDS assessment dated 6/1/23 showed resident #57 had a BIMS score of 0 out 15, indicating severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and psychotic disorder other than schizophrenia. Further review | F 578 | PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR | |

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| F 578 | Continued From page 2<br>showed the resident exhibited no behavioral symptoms and no restraints or alarms were in use. The following concerns were identified:<br>a. Review of the facility incident report dated 5/9/23 showed the administrator was notified RN #1 and RN #2 attempted to provide medication to resident #57 while the resident was combative. The report indicated the nurses held the resident's hands against his/her body and braced the resident's jaw to keep him/her from moving away during medication administration. Further review showed both nurses were suspended pending investigation and, upon return to the facility, were educated related to residents' right to refuse medications, and restraining residents.<br>b. Review of an IDT progress note dated 5/10/23 and timed 12:47 PM showed "...Date, Time and Type of Incident: 5/9/23 @ [at] 21:57 [9:57 PM] Alleged Abuse Description of Incident: Nurse had administered Medications successfully to resident with Yogurt and crushed meds. When it came time to administer Potassium, resident became combative and refusing to take medications. Resident had been in the hospital within the prior 48 hours for low potassium levels and needed this medication to prevent re-hospitilization [sic]. Resident continues to show confusion and refuses medications on a regular basis. Nurse tried 3 other techniques to administer Potassium and they were unsuccessful. Nurse asked 2nd nurse for assistance to administer medication. Resident with their altered mental status continued to swip [sic] and move moouth [sic] away from staff. Nurses held hands against body to prevent staff from being hit. 2nd Nurse braced jaw to alleviate the hard movements so they could administer medications with a syringe for dilluted [sic] liquid potassium. Resident continued to refuse and spit | F 578 | THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.<br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br><br>a. Resident # 57 has passed away.<br><br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br><br>a. An audit was completed on 06/23/23 to identify residents who have severe cognitive impairment and frequently refuse medication. 2 other residents were identified with severe cognitive impairment and refusals of medications. No new concerns of abuse or restraints were identified.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br>a. All staff education completed on 06/26/23 on resident rights, restraints, abuse, and refusal of medications. | |

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| F 578 | Continued From page 3<br>medications out and tried to bite nurse who administered medications. CNA and another staff member witnessed the last attempt to administer and contacted NHA. Both nurses were suspended pending investigation into incident and allegation..."<br>c. Review of the "behavior" care plan last revised on 4/19/23 showed the resident had behavior problems which included hitting staff during care and refusing medications. Further review showed no interventions to hold the resident's arms or head when behaviors occurred.<br>d. Interview with RN #1 on 6/22/23 at 1:24 PM revealed she was involved in the incident on 5/9/23. The RN revealed the resident had previously been sent to the hospital for low potassium and the resident's representative wanted staff to try to get the resident to take his/her medications. At the time of the incident, the nurse was able to administer the other medications, without issue, by putting them in yogurt; however, the resident refused the potassium. The nurse revealed she attempted to administer the potassium 3 different times, (in a medication cup, in juice, and in a syringe) without success. Further interview revealed RN #1 and RN #2, who was assisting her, held the resident's jaw in an attempt to get the resident to take the medication.<br>e. Interview with RN #2 on 6/22/23 at 3:01 PM revealed she was involved with the incident on 5/9/23 as another nurse had asked her to assist to give resident #57 medications. At that time, the other nurse had given the resident's other medications in pudding; however, the resident refused potassium. She stated the other nurse held the resident's hands and RN #2 attempted to give the potassium. She revealed | F 578 | IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br>a. IDT team have resident assignment through ambassador rounds and question/observe assigned residents on/for abuse weekly.<br>b. DON/designee will monitor for abuse/restraints on severely cognitively impaired residents with staff observations twice weekly for four weeks and once weekly for two months and report those findings to the monthly Quality Assurance<br><br>Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.<br><br>Date of Compliance: 07/13/2023 | |

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| F 578 | Continued From page 4 | F 578 | | |

she supported the resident's cheek, but did not grab anything.

f. Interview with CNA #1 on 6/22/23 at 1:39 PM revealed during the incident on 5/9/23, resident #57 refused some medications and the nurse asked CNA #1 to hold the resident's arms against his/her body so she could give the resident the medication; however, he held the resident's hands instead, as a distraction. The CNA revealed when he first observed the nurses with the resident, one of them was restricting the resident's arm movement by placing her hands, palm down, on the resident's forearms against the resident's abdomen. The other nurse grabbed the resident's face and squeezed the resident's cheeks to get him/her to open his/her mouth. The CNA revealed he notified another CNA, who also attempted to hold the resident's hands, and both CNAs reported the incident to the nurse on the other unit. Further interview revealed he did not recall the resident verbalizing pain; however, the resident did spit the medication on RN #1's face.

g. Review of interventions implemented following the incident showed the facility performed 1 to 1 education for the nurses involved on 5/9/23 and all staff were educated on resident rights and restraints on 5/10/23. Review of the QAPI notes dated 5/11/23 showed the facility would implement weekly monitoring for 4 weeks and monthly monitoring for 2 months to include unit/floor observations, observations of nurses involved in the incident, and monitoring of items that may be a resident right violation; however, the facility was unable to provide evidence of the monitoring identified in QAPI.

2. Interview with the DON on 6/22/23 at 2:33 PM revealed if a resident was refusing a medication, she expected staff to attempt to redirect the

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| F 578 | Continued From page 5<br>resident, leave the resident alone, and attempt to re-approach later. Further interview confirmed staff restricting the resident's movement was a restraint and removed the resident's right to refuse medication.<br><br>3. Interview with the administrator on 6/22/23 at 2:39 PM revealed he expected staff to follow resident rights. If residents refuse something, staff should return at a later time to offer again. Further interview confirmed grabbing the resident's face was considered a restraint, and was not a practice that should be performed by staff.<br><br>4. Review of the facility policy titled "Resident Rights" last revised December 2016 showed "...1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:... g. exercise his or her rights as a resident of the facility and as a resident or citizen of the united states;... i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility;... be informed of, and participate in; his her care planning and treatment;... s. choose an attending physician and participate in decision-making regarding his or her care;..." | F 578 | | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not | F 604 | | 7/13/23 |

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| F 604 | Continued From page 6<br>required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview, facility incident report review, and policy and procedure review, the facility failed to ensure residents were free from physical restraints for 1 of 2 sample residents (#57) reviewed for restraint use. The findings were:<br><br>1. Review of the significant change MDS assessment dated 6/1/23 showed resident #57 had a BIMS score of 0 out 15, indicating severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and psychotic disorder other than schizophrenia. Further review showed the resident exhibited no behavioral | F 604 | PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN | |

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| F 604 | Continued From page 7<br>symptoms and no restraints or alarms were in use. The following concerns were identified:<br>a. Review of the facility incident report dated 5/9/23 showed the administrator was notified RN #1 and RN #2 attempted to provide medication to resident #57 while the resident was combative. The report indicated the nurses held the resident's hands against his/her body and braced the resident's jaw to keep him/her from moving away during medication administration. Further review showed both nurses were suspended pending investigation and, upon return to the facility, were educated related to residents' right to refuse medications, and restraining residents.<br>b. Review of an IDT progress note dated 5/10/23 and timed 12:47 PM showed "...Date, Time and Type of Incident: 5/9/23 @ [at] 21:57 [9:57 PM] Alleged Abuse Description of Incident: Nurse had administered Medications successfully to resident with Yogurt and crushed meds. When it came time to administer Potassium, resident became combative and refusing to take medications. Resident had been in the hospital within the prior 48 hours for low potassium levels and needed this medication to prevent re-hospitilization [sic]. Resident continues to show confusion and refuses medications on a regular basis. Nurse tried 3 other techniques to administer Potassium and they were unsuccessful. Nurse asked 2nd nurse for assistance to administer medication. Resident with their altered mental status continued to swip [sic] and move moouth [sic] away from staff. Nurses held hands against body to prevent staff from being hit. 2nd Nurse braced jaw to alleviate the hard movements so they could administer medications with a syringe for dilluted [sic] liquid potassium. Resident continued to refuse and spit medications out and tried to bite nurse who | F 604 | SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.<br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br>a. Resident # 57 has passed away.<br><br>HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br><br>a. An audit was completed on 06/23/23 to identify residents who have sever cognitive impairment and frequently refuse medication. 2 other residents were identified with sever cognitive impairment and refusals of medications. No new concerns of abuse or restraints were identified.<br><br>II. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br>a. All staff education completed on 06/26/23 on resident rights, restraints, abuse, and refusal of medications.<br><br>III. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE | |

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| F 604 | Continued From page 8<br>administered medications. CNA and another staff member witnessed the last attempt to administer and contacted NHA. Both nurses were suspended pending investigation into incident and allegation..."<br>c. Review of the "behavior" care plan last revised on 4/19/23 showed the resident had behavior problems which included hitting staff during care and refusing medications. Further review showed no interventions to hold the residents arms or head when behaviors occurred.<br>d. Interview with RN #1 on 6/22/23 at 1:24 PM revealed she was involved in the incident on 5/9/23. The RN revealed the resident had previously been sent to the hospital for low potassium and the resident's representative wanted staff to try to get the resident to take his/her medications. At that time, the nurse was able to administer the other medications, without issue, by putting them in yogurt; however, the resident refused the potassium. The nurse revealed she attempted to administer the potassium 3 different times, (in a medication cup, in juice, and in a syringe) without success. Further interview revealed RN #1 and RN #2, who was assisting her, held the resident's jaw in an attempt to get the resident to take the medication.<br>e. Interview with RN #2 on 6/22/23 at 3:01 PM revealed she was involved with the incident on 5/9/23 as another nurse had asked her to assist to give resident #57 medications. At that time, the other nurse had given the resident's other medications in pudding; however, the resident refused potassium. She revealed the other nurse held the resident's hands and RN #2 attempted to give the potassium. She stated she supported the resident's cheek, but did not grab anything.<br>f. Interview with CNA #1 on 6/22/23 at 1:39 | F 604 | SURE THE SOLUTIONS ARE SUSTAINED:<br>a. IDT team have resident assignment through ambassador rounds and question/observe the assigned residents on/for abuse weekly.<br>b. DON/designee will monitor sever cognitively impaired residents with staff observations twice weekly for four weeks and once weekly for two months and report those findings to the monthly Quality Assurance<br><br>Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.<br>Date of Compliance: 07/13/2023 | |

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| F 604 | Continued From page 9<br>PM revealed during the incident on 5/9/23, resident #57 refused some medications and the nurse asked CNA #1 to hold the resident's arms against his/her body so she could give the resident the medication; however, he held the resident's hands instead, as a distraction. The CNA revealed when he first observed the nurses with the resident, one of them was restricting the resident's arm movement by placing her hands, palm down, on the resident's forearms against the resident's abdomen. The other nurse grabbed the resident's face and squeezed the resident's cheeks to get him/her to open his/her mouth. The CNA revealed he notified another CNA, who also attempted to hold the resident's hands, and both CNAs reported the incident to the nurse on the other unit. Further interview revealed he did not recall the resident verbalizing pain; however, the resident did spit the medication on RN #1's face.<br>g. Review of interventions implemented following the incident showed the facility performed 1 to 1 education for the nurses involved on 5/9/23 and all staff were educated on resident's rights and restraints on 5/10/23. Review of the QAPI notes dated 5/11/23 showed the facility would implement weekly monitoring for 4 weeks and monthly monitoring for 2 months to include unit/floor observations, observations of nurses involved in the incident, and monitoring of items that may be a resident right violation; however, the facility was unable to provide evidence of the monitoring identified in QAPI.<br><br>2. Interview with the DON on 6/22/23 at 2:33 PM revealed if a resident was refusing a medication, she expected staff to attempt to redirect the resident, leave the resident alone, and attempt to re-approach later. Further interview confirmed staff restricting the resident's movement was a | F 604 | | |

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| F 604 | Continued From page 10 | F 604 | | |

restraint and removed the resident's right to refuse medication.

3. Interview with the administrator on 6/22/23 at 2:39 PM revealed he expected staff to follow resident rights. If residents refuse something, staff should return at a later time to offer again. Further interview confirmed grabbing the resident's face was considered a restraint and was not a practice that should be performed by staff.

4. Review of the facility policy titled "Resident Rights" last revised December 2016 showed "...1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:... d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms..."

5. Review of the facility policy titled "Identifying Involuntary Seclusion and Unauthorized Restraint" last revised April 2021 showed "...Unauthorized Physical Restraints...2. Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: a. Is attached or adjacent to a resident's body; b. Cannot be removed easily by the resident (in the same manner it was applied by the staff); and c. Restricts the resident's freedom of movement or normal access to his/her body. 3. Inappropriate or unauthorized use of a restraint occurs when it: a. is used for discipline or convenience; b. unnecessarily inhibits a resident's freedom of movement or activity; c. is not the least restrictive option or used for the least amount of time needed; and/or d. is not accompanied by ongoing

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| F 604 | Continued From page 11<br>re-evaluation of the need for the restraint. 4. Sometimes the use of restraints is not intentional, but this does not absolve the staff of the responsibility to recognize and report the unauthorized use of restraints. Examples of physical restraints (intentional or unintentional) include:...h. holding down a resident in response to a behavioral symptom or during the provision of care if the resident is resistive or refusing the care..." | F 604 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§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:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§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;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F 758 | | 7/13/23 |

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| F 758 | Continued From page 12<br><br>§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<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>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 6 sample residents (#5, #11) who received psychotropic medications. The findings were:<br><br>1. Review of the quarterly MDS assessment dated 4/3/23 showed resident #5 had a BIMS score of 12 out of 15, indicating the resident was cognitively intact, and diagnoses which included anxiety, bipolar disorder, and attention deficit hyperactivity disorder. Review of section N, "Medications," showed the resident received antipsychotic medications and antianxiety medications on 7 days during the look-back | F 758 | PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF | |

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| F 758 | Continued From page 13<br>period. Review of physician orders showed the resident received Klonopin (antianxiety) 0.5 milligram (mg) for anxiety, lithium carbonate (mood stabilizer) 300 mg two times per day related to bipolar disorder, quetiapine fumarate (antipsychotic) 25 mg two times a day related to bipolar disorder, and Topamax (anticonvulsant) tablet 50 mg three times a day related to bipolar disorder. The following concerns were identified:<br>a. Review of the care plan for psychotropic medication related to bipolar disorder last revised on 10/26/22 showed interventions which included to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation's, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, and behavior symptoms not usual to the person. Further review showed no evidence of specific target symptoms related to the use of individual medications.<br>b. Review of the medication administration record (MAR) and treatment administration record (TAR) for June 2023 showed no evidence of monitoring the resident for side effects related to the use of psychotropic medications, identified target symptoms, nor effectiveness specific to the use of each psychotropic medication.<br><br>2. Review of the quarterly MDS assessment dated 4/28/23 showed resident #11 had a BIMS score of 15 out of 15, indicating the resident was cognitively intact, and diagnoses which included | F 758 | PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.<br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br>a. Residents #5 and #11 have had specific behavior tracking placed for psychotropic medications. Care plans have been updated accordingly.<br>b. Side effect monitoring is placed on both residents for all psychotropic medications. Care plans adjusted accordingly.<br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br>a. Audit completed of all residents receiving psychotropic medications on 6/28/23.<br>b. Orders and care plans have been updated to reflect side effect monitoring and target behavior tracking for every psychotropic medication.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br>a. Batch orders have been placed in EMAR system for side effect monitoring and target behavior monitoring including the number of episodes, ensuring provider | |

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| F 758 | Continued From page 14<br>anxiety, bipolar disorder, schizophrenia, and PTSD. Review of section N, "medications," showed the resident received antipsychotic and antianxiety medications on 7 days of the look-back period. Review of the physician orders showed the resident received aripiprazole (antipsychotic) 15 mg one time a day related to bipolar disorder, Depakote (anticonvulsant) delayed release 250 mg at bedtime related to bipolar disorder, Effexor (antidepressant) extended release 150 mg one time a day related to bipolar disorder, and quetiapine fumarate (antipsychotic) tablet 200 mg at bedtime for bipolar/schizophrenia. The following concerns were identified:<br>a. Review of the care plan for antipsychotic medications last revised on 10/13/22 showed interventions which included to administer antipsychotic medications as ordered by physician, observe for side effects and effectiveness every shift, and educate [resident name], legal guardian, family/caregivers about risks, benefits and the side effects and/or toxic symptoms related to psychotropic medication drugs being given. Further review showed no evidence of specific target symptoms related to the use of individual medications.<br>c. Review of the medication administration record (MAR) and treatment administration record (TAR) for June 2023 showed no evidence of monitoring of the resident for side effects related to the use of psychotropic medications, identified target symptoms, nor effectiveness specific to the use of each psychotropic medication.<br><br>3. Interview with LPN #1 on 6/21/23 at 2:21 PM revealed the nursing staff monitor for behaviors in the treatment administration records (TAR). At | F 758 | and staff can monitor effectiveness of psychotropic medication.<br>b. All nurses have been educated on psychotropic medication expectations which include target symptoms/behaviors, side effect monitoring and effectiveness.<br><br>IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br>a. DON/designee will review all new admissions during daily clinical meetings to ensure that all psychotropic medications have target behaviors and side effect monitoring placed. Any concerns identified will be corrected immediately. Findings will be reported through the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.<br><br>Date of Compliance: 07/13/2023 | |

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| F 758 | Continued From page 15<br>that time, she verified that the monitoring for psychotropic medications was not on the TAR and stated since it was not on the TAR the facility was not monitoring resident behaviors.<br><br>4. Interview with the administrator and the regional director of clinical compliance on 6/21/23 at 3:50 PM revealed the facility was monitoring behaviors in the task table; however, the behaviors were not targeted to the medications and staff were expected to document on the TAR. Further, they confirmed the orders were not on the TAR.<br><br>5. Review of the "Behavior Documentation Protocol" not dated showed "...If a resident has a psychotropic medication facility must ensure that there is behavior tracking in place for each medication with specific behaviors for the medication based on residents' behavioral history..." | F 758 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | F 880 | | 7/13/23 |

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| F 880 | Continued From page 16<br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents | F 880 | | |

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| F 880 | Continued From page 17<br>identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection control techniques were implemented for 1 of 5 residents (#177) reviewed for wounds. The findings were:<br><br>1. Review of the current physician orders showed resident #177 received amoxicilillin-pot clavilanate (antibiotic) 875-125 mg by mouth every 12 hours for a bacterial infection of the left forearm. The following concerns were identified:<br>a. Observation on 6/21/23 at 9:52 AM showed LPN #1 entered the room of the resident, donned gloves and prepared supplies to apply a dressing to the resident's left forearm. At that time, the wound on the resident's left forearm was open to air. The LPN cleaned the wound, applied silvadene cream, applied non-adherent pads, and then applied a clean rolled gauze over the wound. Upon completing the dressing application, she doffed her gloves. No hand hygiene or glove change was performed between cleaning the wound, and applying the dressing. Interview with the LPN on 6/21/23 at 9:58 AM revealed she normally performed wound dressing changes in the manner observed. Further interview | F 880 | PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.<br>I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT | |

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| F 880 | Continued From page 18<br>confirmed she had not changed gloves or performed hand hygiene between cleansing the wound and the clean dressing application.<br><br>3. Interview with the regional director of clinical compliance on 6/21/23 at 10:05 AM revealed the facility expectation was for staff to wash their hands and don clean gloves between each step of the wound care treatment.<br><br>4. Review of policy and procedure "Wound Care" Med-Pass, Inc. (revised October 2010) showed "... 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over the dressing and discard into the appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves... 13. Dress wound..." | F 880 | PRACTICE:<br>a. Resident # 177 wound care was redone on 6/21/23 when nurse manager became aware of the concern.<br>b. Education completed with the LPN on proper wound care techniques per the policy and procedures on 06/23/2023<br>II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:<br>a. All residents with wounds are at risk for alleged deficient practice.<br><br>III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:<br>a. All nursing staff who preform wound care have been educated on the policy and procedures to maintain infection control and Hand hygiene.<br>IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:<br>b. DON/designee will complete infection control audits and hand hygiene during wound care 2 x per week for 3 months. Any concerns identified will be corrected immediately. Findings will be reported through the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further | |

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| F 880 | Continued From page 19 | F 880 | monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee.<br><br>Date of Compliance: 07/13/2023 | |