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	535040	A. BUILDING _____ B. WING _____	C 11/15/2024

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DOUGLAS CARE CENTER LLC	**1108 BIRCH STREET DOUGLAS, WY 82633**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 11/12/24 to 11/15/24. Also reviewed in the course of the survey were complaint intakes WY00003852, WY00003874, and WY00003936. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Sheet NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	F 661		12/20/24

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

Electronically Signed | 12/03/2024

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F 661	Continued From page 1 representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 4 resident-initiated discharges (#97) reviewed. The findings were: Review of the 7/17/24 MDS discharge assessment for resident #97 showed s/he was admitted to the facility on 7/11/22 and was discharged to a short-term general hospital on 7/17/24 with a return to the facility not anticipated. Further review of the medical record showed no evidence a discharge summary had been completed. Interview on 11/14/24 at 5:15 PM with the NHA confirmed the discharge summary had not been completed.	F 661	Plan of Correction F661: Discharge Summary CFR(s): 483.21¿(2)(i)-(iv) The facility will ensure that a discharge summary will be completed which will include a recapitalization of each residents stay. 1. Resident #97 had a discharge summary completed on 11/15/24 2. This deficiency could affect all residents. 3. MDS or designee will complete all discharge summaries for residents with return not anticipated at the time of discharge. 4. NHA or designee will educate IDT team	

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F 661	Continued From page 2	F 661	to complete discharge summaries. 5. MDS nurse and/or designee will conduct a weekly audit of all discharge with return no anticipated to ensure a discharge summary has been completed. 6. MDS nurse or designee will perform an audit of all discharge-return not anticipated- for the last 6 months and ensure discharge summaries are complete. 7. The IDT team will review at QAPI monthly for 90 days or until resolved.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		12/20/24

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F 700	Continued From page 3 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to ensure bed rails were evaluated for safety on a regular basis for 1 of 2 residents (#15) reviewed with bed rails. The findings were: 1. Observation on 11/12/24 at 1:15 PM showed resident #15 had an assist bar, bilaterally, at the head of the bed. Review of the resident's medical record showed the last "assist bar evaluation" was completed on 4/6/21. Interview with the MDS coordinator on 11/13/24 at 4:20 PM revealed safety assessments should be conducted annually and confirmed no further documentation was available. 2. Review of the 2/13/23 "Use of Assistive Devices" policy showed "...2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care....4. DCC staff will provide appropriate assistance to ensure that the resident can use the assistive devices. This may include education or therapy sessions for training on the use of the device, safety evaluations, set up assistance, supervision, or physical assistance as needed...6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device..."	F 700	Plan of Correction F700 Bedrails CFR(s): 483.25(n)(1)-(4) The facility will ensure that bedrails are evaluated for safety on a regular basis, i.e. at comprehensive or significant change care plans. 1. Resident number 15 had an evaluation for the bedrail performed by MDS nurse on 11/13/24. 2. This deficiency can affect all residents 3. Safety evaluations for bedrails will be incorporated with all other comprehensive safety evaluations or charge of conditions that are completed by physical therapy and/or occupations therapy or designee. 4. IDT and therapies will be educated by NHA or designee that all bedrails evaluations are performed annually or with significant changes. 5. Restorative CNA or designee will perform audit of all residents who currently have bed rails to ensure proper safety evaluations are completed. 6. IDT members will be assigned halls and will check them monthly to ensure that all bedrail evaluations are completed within the time frame or at significant	

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F 700	Continued From page 4	F 700	change. 7. Audits will be brought to QAPI every month for 90 days or until resolved.	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on nursing staff schedule review and staff interview, the facility failed to have a system in	F 725	F725	12/20/24

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F 725	Continued From page 5 place to document licensed nurses in the facility on a 24-hour basis. The findings were: 1. Review of the PBJ (payroll-based journal) Staffing Data Report for July 1 through Sept 30, 2023 showed the following concerns: a. The PBJ showed the facility failed to provide nursing coverage 24 hours/day on 7/21, 7/23, and 7/30. b. Review of the working schedule showed on 7/21 the DON was on duty for 12 hours starting at 6 AM. On 9/10, 9/23, and 9/30 the DON was shown as working a 12-shift starting at 6 PM. The other days noted on the PBJ were covered by nursing staff. 2. Review of the "PBJ Staffing Data Report" for October 1 through December 31, 2023 showed the following concerns: a. The PBJ showed the facility failed to provide nursing coverage 24 hours/day on 10/1, 10/8, 10/29, 11/23, 12/2, 12/3, and 12/9. b. Review of the working schedule showed on 10/29 the DON worked a 12-hour shift starting at 6 AM. On 11/23 the DON worked 12 hours starting at 6 PM. In December the schedule showed the DON worked 12 hours started at 6 PM on 12/2. The other days noted on the PBJ were covered by nursing staff. 3. Interview with the NHA on 11/15/24 at 8:55 AM revealed she had only been doing the PBJ for couple of months. The former PBJ data entry person was no longer employed. Further, she stated the DON was salary, and was unable to clock in without causing problems with the payroll system. She stated there was no way of proving the DON had worked the floor, except showing it on the schedule. She stated the facility had	F 725	Sufficient Nursing Staff CFR:483.35(a)(1)(2) Douglas Care Center will ensure that a system is in place to document licensed nurses in the facility on a 24 hour basis. 1. DON will be treated like a contract staff in our time clock system 2. DON’s hours will be manually imputed when she is working the floor as she is our only salaried nurse. 3. Human resource or payroll designee will be imputing DON’s hours manually 4. NHA or designee will educate staff member who will be imputing DON’s hours manually 5. Human resource or payroll designee will perform an audit with each pay cycle to ensure DON hours, if worked the floor, are manually imputed and match the schedule. 6. This will be brought to QAPI monthly for 90 days or until resolved.	

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F 725	Continued From page 6 recognized the problem and had added a performance improvement project to their quality assessment.	F 725		
F 740 SS=G	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 2 of 4 residents (#4, #97) reviewed for behavioral and emotional needs. This failure resulted in actual harm to resident #97. The findings were: 1. Review of the 7/17/24 MDS discharge assessment for resident #97 showed s/he was admitted to the facility on 7/11/22 and was discharged to a short-term general hospital on 7/17/24 with a return to the facility not anticipated. Review of the 4/23/24 quarterly MDS assessment showed the resident had diagnoses which included non-traumatic brain dysfunction and non-Alzheimer's dementia. Further review	F 740	F740 Behavioral Health Services CFR(s): 483.40 The facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental and psychosocial well-being 1. a. Douglas Care Center received psychological letter from Dr. Santiago□s office on 05/07/2024 was in our emails and had not been uploaded into our medical records. It will be uploaded to his medical files on 12/03/2024 b. The IR information that was uploaded to the state IR form was not carried over to the appropriate care plans. c. Resident #97 should have had all interventions care planned, they were	12/20/24

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F 740	Continued From page 7 showed the resident had a staff assessment for mental status which indicated moderate cognitive impairment, disorganized thinking which fluctuated in severity, exhibited verbal behavioral symptoms directed towards others 1 to 3 days of the 7-day look-back period, behavioral symptoms not directed toward others 4 to 6 days of the 7-day look-back period, and rejected care 1 to 3 days of the 7-day look-back period. The resident was coded as receiving an antianxiety medication. Review of the 12/6/23 Office Physician Progress note showed a "hearing was held last week before [judge's name] to determine the patient's need for a power of attorney, and to seek placement where [s/he] could get more effective care for [his/her] emotional disturbances and be less disruptive to other patients around." The progress note showed the resident had a diagnosis of aggressive behavior due to dementia. Review of a subsequent note showed the court determined the resident to be incompetent on 12/15/23. Review of a 2/28/24 physician's verbal order showed an order was placed for the resident to have a psychological evaluation. The verbal order was signed by the physician on 3/6/24. The following concerns were identified: a. Review of the resident's entire medical record showed no evidence a psychological evaluation had been completed. b. Review of the Event Reports from 3/3/24 to 6/29/24 showed the resident had aggressive/combative behaviors on 3/3, 3/18, 3/19, 3/22, 3/27, 4/3, 4/13, 5/8, 5/18, 6/13, 6/20, and 6/29. c. Review of the resident's care plan showed a description of resident-to-resident interactions which occurred on 1/31/24, 2/12/24, 2/14/24, 3/7/24, 3/18/24, 3/19/24, 3/22/24, 3/24/24,	F 740	appropriately documented within the IR system, however they were not carried over to the care plan. Resident has since been discharged on 07/17/2024. 2. a. Resident #4 will have all follow ups done and documented when stating he or she wants to take or own life, or wishes death upon her. b. b. The facility now has a current policy on suicidal behaviors. c. This deficiency has a potential of affecting all residents. d. The facility in search of licensed clinical social worker. e. A form has implemented that charge nurse needs to fill out when someone is exhibiting suicidal behaviors. The form will be sent to medical director or designee for further instructions. f. DON or designee will educate all charge nurses which was performed on 11/14/2024 of new policy. g. IDT team will meet weekly to discuss all behavioral events. h. Social Service or designee will audit ALL current behavioral care plans and ensure interventions match state incident reports, if applicable and are in place. i. NHA or designee will perform monthly audits of ALL behavioral events and ensure all documentation and follow ups have been completed. j. Results of monthly audits will be	

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F 740	Continued From page 8 6/13/24, 6/20/24, and 6/29/24; however, the only intervention noted was 3/14/24 which showed "My staff will attempt to place a stop sign in my doorway to keep other residents from wandering into my room." The previous interventions related to resident-to-resident interactions or behaviors were dated on or before 8/29/23. d. Review of the resident's care plan under the category of "Special treatments" last edited on 4/24/24 showed "I will break my furniture in my room. My bed is zip tied to itself so I can't bang it on the ground. I broke the door on my nightstand, so it has been removed for my safety." e. Review of the resident's care plan under the category of "Call Light", dated 5/8/24 showed "My call light cords were removed for my safety and the safety of others around me due to me trying to use call light cords as whips. Call light stoppers were placed where cords were. My staff will attempt to anticipate my needs." f. Review of a progress note dated 7/17/24 and timed 10:28 PM showed "pt (patient) stuck (sic) a female resident in the lower back with the back of [his/her] hand while [s/he] was walking down the hall...female suffered no apparent injury, pt's behavior continued to escalate until two staff members had to barrackade (sic) themselves along with some of the patients in two different rooms to protect themselves and patients from pt's violent behavior, charge nurse called 911 for help, officers deesalated (sic) pt's aggitation [sic], guardian and [a mental health service] were called, a zoom mental health evaluation was performed on pt, emt's [sic] were called and pt was taken from facility, md notified." g. Review of a progress note dated 7/19/24 showed the resident's guardian had notified the facility that the judge had granted an official order to have the resident placed in the state hospital.	F 740	brought to QAPI monthly for 90 days or until resolved.	

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h. Interview with the NHA on 11/14/24 at 4:12 PM revealed she had an email chain related to the scheduling of the resident for a psychological evaluation which showed that due to the rural location of the facility the evaluation was not scheduled; however, an appointment with a neurologist had been scheduled for 4/10/24. The NHA confirmed no documentation of the attempts to schedule the psychological evaluation or the neurologist's progress notes had been documented in the resident's medical record.

2. Review of the 9/13/24 quarterly MDS assessment showed resident #4 was re-admitted from an acute care hospital to the facility on 3/1/24 and had diagnoses which included cerebrovascular accident, non-Alzheimer's dementia, depression and bipolar disorder. The resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed the resident did not exhibit physical or verbal behavioral symptoms or rejection of care. Review of the resident's care plan, dated 3/22/23, showed, "When I have suicidal ideations or similar behaviors my staff will try to redirect me, they may offer me to call my counselor that I see or my family. They may take me to the common area or dining room to visit and interact with people and so my staff can ensure my safety." Further review showed the resident received antipsychotic and antidepressant medications, and the last gradual dose reduction was clinically contraindicated by the physician on 2/21/24. The following concerns were identified:

a. Review of a progress note dated 6/8/24 at 1:39 PM showed a CNA notified RN #1 of a note found on the resident's bedside table that stated "I wish I was dead please let me die." The

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administrator on call and the resident's son were notified. The resident's son did not want the resident sent to the emergency department, and arrived at the facility to talk to the resident, who told his/her son s/he was "just venting [his/her] feelings." Further review showed no follow up documentation.

b. Review of a progress note dated 7/4/24 at 9:11 AM showed the resident sat in the hall and yelled at staff. Further review showed the resident stated "I want to die; I am going to kill myself." RN #2 reported the resident's statement to the DON and the charge nurse. Further review showed no follow up documentation.

c. Review of a progress note dated 9/21/24 at 12:40 PM showed CNA #1 reported a note was found on the resident's table that read, "I wish I was dead; Please I was dead." The on-call administrator and resident's emergency contact were notified, and the emergency contact responded "watch [him/her] and if you need any thing [sic] let me know." The plan was to monitor the resident. The resident was documented by CNA #1 as laughing with housekeeping staff at 12:50 PM, and sleeping comfortably at 1:55 PM and 3:32 PM. At 5:49 PM the resident was documented as screaming at the CNA. No further behaviors were documented on 9/21/24.

d. Review of a progress note dated 11/6/24 at 7:25 AM showed CNA #2 answered the resident's call light. The resident was asleep, and the CNA saw a note on the resident's bedside table that read in part, "I wish I was dead." The CNA texted LPN #1 a copy of the note, and the nurse immediately checked on the resident and found the resident asleep in his/her recliner in no obvious sign of distress. The nurse notified the DON and the NHA at 7:08 AM. The nurse called the resident's power of attorney (POA) at 7:24 AM

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and informed her about the note that was found in the resident's room. The POA stated she was aware the resident had these thoughts. The nurse informed the POA that the resident was asleep and not in current distress, and would be monitored by staff.

e. Review of a progress note dated 11/6/24 at 9:41 AM showed a mental health agency was contacted by the administrator after being notified about the note.

f. Review of a progress note dated 11/6/24 at 11:44 AM showed the mental health agency phoned to say a referral had been placed for local staff, and they would reach out with the best way to proceed. Further review of the medical record showed no evidence of any follow-up.

g. Interview with the NHA on 11/13/24 at 4:54 PM revealed the mental health agency had stopped seeing the resident several months ago as they did not think their services benefited the resident. The administrator revealed the resident's daughter was called about the note on 11/6/24 and the facility was waiting on the mental health agency to proceed. No one-on-one was provided for the resident at the time the note was found. The facility did not have a current policy on suicidal behaviors.

h. Interview with LPN #2 on 11/14/24 at 2:52 PM revealed the resident had been told s/he would need to be observed in the dining room if s/he mentioned any suicidal ideations. The nurse stated the resident would often say s/he "didn't mean it."

i. Interview with the social worker on 11/15/24 at 11:13 AM revealed she did not document conversations with residents; however, she communicated any resident behaviors to the nursing staff. Further, the interview revealed care plan interventions should be documented in the

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F 740	Continued From page 12 progress notes.	F 740		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (#98) reviewed for dementia care. The findings were: 1. Review of the 9/6/24 quarterly MDS assessment for resident #98 showed the resident was admitted to the facility on 6/6/23 and had diagnoses which included alcohol dependence with alcohol-induced persisting dementia, anxiety disorder, and depression. The resident had a BIMS score of 4 out of 15 indicating severe cognitive impairment. Further review showed the resident was coded as being administered an antidepressant. A resident-initiated transfer to another long-term care facility occurred on 9/9/24. The following concerns were identified: a. Review of the Event Forms from 8/5/24 through 9/5/24 showed the resident had a resident-to-resident altercation with aggressive/combative behaviors on 5/10, 5/18, 7/13, 7/31, 8/18, 8/20, and 9/5. b. Review of the resident's care plan in the category of "Resident-to-Resident Altercation",	F 744	F744 Treatment /Services for Dementia CFR(s): 483.40(b)(3) Douglas Care Center will ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental and psychosocial well-being. The IR information that was uploaded to the state IR form was not carried over to the appropriate care plans. Resident #98 should have had all interventions care planned, they were appropriately documented within the IR system, however they were not carried over to the care plan. Resident has since been discharged on 09/09/2024. There should have been a Behavioral care plan however resident was discharged from facility on 09/09/24. All residents have the potential to be	12/20/24

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F 744	Continued From page 13 dated 9/4/24, showed the "Approach" section of the care plan gave a description of the resident-to-resident altercations which occurred on 3/2/24, 3/7/24, 3/11/24, 3/13/24, 3/15/24, 3/18/24, and 4/9/24; however, the care plan failed to include any interventions. c. Review of the "Cognitive Loss/Dementia" care plan, dated 11/29/23, showed interventions which included "my staff will direct me to my room, activities, or meals as needed to assist me." and "My staff will reassure my safety as needed if I am confused." d. Review of the "Behavioral Symptoms" care plan, dated 6/22/23, showed the resident may become verbally and physically aggressive and interventions included to "...distract me with one of the robotic therapy animals", "I tend to calm down better after I have been left alone for awhile (sic)." and "My staff will reassure me of my safety and explain what they are doing when they are helping me." e. Review of an "Office Physician Progress Note", dated 5/1/24, showed "Patient is easily awoke with verbal cue. Initially disgruntled but noncombative and became interactive. Per nursing staff patient does have strong medications that are causing [him/her] to be somnolent and rarely gets out of bed until later in the afternoon. No other acute concerns per nursing staff." Further review of the progress note showed no assessment or behavioral care plan had been developed. f. Review of an "Office Physician Progress Note", dated 7/18/24, showed "Patient continues to be extremely somnolent and does not react well to being woken up during any encounters. Per nursing staff and director of nursing they have no acute complaints at this time..." Further review of the progress note showed no	F 744	affected by this deficiency of lack of treatment or inservices for dementia. All residents who have behaviors will be care planned. MDS or designee will educate IDT on physician progress notes being reviewed and acknowledged and if needed, a clarification note from nursing staff back to provider. Social Services or designee to audit physician notes, once received and acknowledged by nursing staff, to ensure any updates or changes need to be made. All audit will be brought to QAPI monthly for 90 days or until resolved.	

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F 744	Continued From page 14 assessment or behavioral care plan had been developed. g. Review of a progress note, dated 8/29/24, showed "Resident was on the schedule today at 1 PM for a counseling appointment. Looking into [his/her] chart and on the appointment it was unclear where this was supposed to be at." Further the note stated the mental health agency had been called and "no one had [the resident] in their records. Patient at this time has been combative so this appointment has been canceled at this time due to behavior as well not knowing where this was to be at." h. Review of the 6/12/24 Interdisciplinary Care Plan Conference Record showed the social service director had no concerns, nursing staff addressed the need for dental work, the family were happy to hear the resident had gained weight, and activities and dietary had no concerns. There was no documentation the resident's behaviors had been discussed. i. Interview with the social worker on 11/15/24 at 11:12 AM revealed she was involved in the resident's care; however, she does not document the encounters in the resident's record. Further, resident's behaviors were communicated to the administrator or the nursing staff and they made the decisions. j. Interview with the former NHA on 11/15/24 at 11:43 AM confirmed the facility failed to have a system in place to ensure a professional evaluation of the resident's behaviors was completed and effective interventions were developed. In addition, the former NHA revealed the medical director had not been consulted.	F 744		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		12/20/24

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F 745	Continued From page 15 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. 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 medically related social services were provided for 1 of 1 sample residents (#4) reviewed with a PASRR (Preadmission Screening and Resident Review) Level II. The following concerns were identified: 1. Review of the 9/13/24 quarterly MDS showed resident #4 was re-admitted from the hospital to the facility on 3/1/24 and had diagnoses which included cerebrovascular accident, non-Alzheimer's dementia, depression and bipolar disorder. The resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed the resident did not exhibit physical or verbal behavioral symptoms or rejection of care. Review of the resident's care plan dated 3/22/23 showed "When I have suicidal ideations or similar behaviors my staff will try to redirect me, they may offer me to call my counselor that I see or my family. They may take me to the common area or dining room to visit and interact with people and so my staff can ensure my safety." Further review showed the resident received antipsychotic medication and antidepressant medication, and the last gradual dose reduction was clinically contraindicated by the physician on 2/21/24. The following concerns were identified: a. Review of the PASRR Level II dated 4/15/21 recommended rehabilitative services to be provided in the nursing facility which included	F 745	F745 Provision of medially related social services CFR(s): 483.40(d) Douglas Care Center will ensure medically related social services were provided. 1. a. A psychiatric evaluation referral and appointment will be made for resident #4. b. Social Service Director or designee will send referrals out to other facilities. c. All residents have the potential to be affected by the provisions of related social services. d. An annual psychiatric check of for anyone who triggers for a PASRR II will be added to care plan check off sheet. e. Social service or designee will educate care plan IDT team that anyone who triggers for PASRR II will be referred to annual psychiatric evaluation. f. Social Service Director, or designee,	

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F 745	Continued From page 16 supportive counseling from nursing facility staff, minimum of an annual comprehensive psychiatric evaluation to clarify the current psychiatric diagnosis, and an appropriate treatment plan. b. Review of the resident's medical record showed no evidence an annual psychiatric evaluation had been completed. c. Review of a progress note, dated 7/19/24, showed the resident told helping hand aide #1 s/he was not happy at the facility and wanted to look into moving to another facility. The aide notified the social services director and the DON. Further review showed no documentation or follow-up to this conversation. d. Interview with the social worker on 11/15/24 at 11:13 AM revealed she did not document conversations with residents, and she took any resident behaviors to the nursing staff. In addition, the social worker revealed care plan interventions should be documented in the progress notes.	F 745	will perform audit of all residents who have triggered for a PASRR II and will make appropriate referrals for psychiatric follow-up. g. Audits from November care plans who had a PASRR II will be scheduled for psychiatric evaluation. h. Audits will be brought to QAPI monthly for 90 days or until resolved.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A	F 801		12/20/24

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qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or

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F 801	Continued From page 18 (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager met the required qualifications. The facility census was 43. The findings were: 1. Interview with the dietary manager on 11/14/24 at 2:08 PM revealed she had not completed the Certified Dietary Manager coursework; however, planned to have it done soon. Further interview with the dietary manager revealed the facility had a dietician on site every Tuesday for 8 hours.	F 801	F801 Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) Douglas Care Center will ensure the dietary manager meets the required qualifications. a. Dietary manager will get enrolled in classes to be a certified dietary manager.	

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F 801	Continued From page 19	F 801	b. This deficiency has the potential to affect all residents. c. c. Current Dietary Manager will enroll in and complete certified food service manager certification within 2 weeks. d. NHA or designee will educate dietary managers that she needs to be enrolled to receive her certified dietary manager certification. e. Dietary manager will bring progress of classes to monthly QAPI until certification is received.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F 880		12/20/24

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F 880	Continued From page 20	F 880		

arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(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
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 21 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and policy and procedure review, the facility failed to implement a water management program to prevent, detect, and control the risk of water-borne pathogens. In addition, the facility failed to conduct an annual review of its infection prevention and control program (IPCP). The census was 43. The findings were: 1. Review of the facility's "Infection Prevention and Control Program" policy showed it was implemented on 5/22/23. There was no evidence the facility had conducted an annual review of its IPCP and updated their program, if necessary. 2. Review of the 5/22/23 IPCP policy showed "...17. Water Management: a. A water management program has been established as part of the overall infection prevention and control program. b. Control measures and testing protocols are in place to address potential hazards associated with DCC's water systems. c. The Maintenance Director along with the Safety Committee serves as the leader of the water management program." Review of the 5/2021 "Legionella Surveillance" policy showed "...2. In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies". These strategies included diagnostic testing, investigation for a facility source of Legionella, physical controls,	F 880	F880 Infection and Prevention CFR(s): 483.80(a)(1)(2)(4)(e)(f) Douglas Care Center will ensure implementation of water management program to prevent, detect and control the risk of the water-borne pathogen as well as conduct an annual review of the infection prevention and control program. a. The facility will conduct an annual review of the infection prevention and control program. b. The facility will implement a primary prevention strategy that include diagnostic testing, investigation for a facility source of Legionella, physical controls and temperature controls. c. This deficiency has the potential to affect all residents. d. NHA or designee will educate infection control and safety committee that the infection control program will be reviewed annually and signed off on	

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F 880	Continued From page 22 and temperature controls. There was no documentation the facility had performed the primary prevention strategies. 3. Interview with the former NHA on 11/15/254 at 11:34 AM confirmed the IPCP policy had not been reviewed in the past year and no documentation was available to show the water management program had been implemented.	F 880	e. NHA or designee will educate safety committee on Legionella policy. f. Infection control program will bring results of review of their program to QAPI monthly for 90 days or until resolved. g. Safety committee will bring results of review of Legionella policy showing diagnostic testing, investigation for a facility source of Legionella, physical controls and temperature controls to QAPI monthly for 90 days or until resolved.	