STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY9071	A. BUILDING _____ B. WING _____	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 An initial certification survey was conducted by Healthcare Licensing and Surveys from 7/23/24 to 7/26/24. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the	F 574	F0574-Required Notices and contact information 1) This facility acknowledges that it is the residents right to have oral or written notice of required notice such as advocacy and state agencies. The state agency and advocacy groups' names, addresses, and telephone numbers have been posted in public space that is easily accessible to all veterans and visitors. Each Veteran was educated individually on location of this information. 2) Each veteran of the current 18 veterans had 1:1 education on location of postings. Staff where educated in person on 8/26/24 and 8/28/24 with understanding verified. 3) Implementation of new admission assessment and admission check sheet to include education on postings and location. This education will be readdress with care conference with each veteran quarterly. Education in the orientation process for newly hired staff to include required postings and there location. 4) Monthly audits will be performed for any new admission or readmissions and care conference notes will be reviewed for education on location of required postings taking place. Will also complete monthly	Completed 8/28/2024

			audit of new employee orientation for compliance with education regarding required postings. During Quality assurance the audits will be reviewed for compliance for the previous month with a goal of 100% compliance. The plan will be adjusted as needed to obtain this goal. Audits will be completed monthly these audits will be assessed at Quality Assurance for 3 months with a completion date of 8/28/20242024.		
	Hwy Meredith	ADMIN	8-30-24		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE	(X6) DATE

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 574	Continued From page 1 State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing	F 574		12/02/2024

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F 574	Continued From page 2 facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure access to state agency and advocacy groups' names, addresses, and telephone numbers. The census was 18. The findings were: 1. Interview with 4 residents during the resident council meeting on 7/24/24 at 2 PM revealed they did not know who the state agencies or advocacy groups were or how to contact them. 2. Observation of the Cottonwood cottage on 7/23/24 at 4:41 PM confirmed state agency and advocacy information was not available. 3. Interview with RN #1 on 7/23/24 at 4:41 PM confirmed state agency and advocacy information was not available. Further interview revealed she "did not know about the Ombudsman information but would find out from the DON." 4. Interview with RN #1 on 7/23/24 at 5:00 PM, revealed the DON confirmed state agency and advocacy information was not available. 5. Review of the policy titled "Grievance" last revised on 12/4/23 showed " ...the community will inform Veterans orally and in writing of their rights to make Complaints and Grievances and the process to do so during admission, readmission and the care planning process. The notice shall	F 574		

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F 574	Continued From page 3 include contact information of independent entities with whom grievances may be filed including Wyoming State Survey Agency and State Long Term Care Ombudsman program ..."	F 574		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and	F 576	F0576-Right to forms of communication w/Privacy 1) This facility acknowledges that it is the residents right to receive mail on Saturdays. The Survey identified 4 veterans thru interviews that stated they did not receive mail on Saturdays. This was verified thru staff interview as well as no existing policy for mail delivery. Plan was developed for designated employee to deliver mail to the cottages on Saturdays. Policy R-13 Mail was created and approved to reflect Saturday mail delivery. 2) All 18 veterans presently living in the facility were identified as not receiving mail on Saturday. A new process and policy was developed, to ensure Saturday mail delivery. 3) On Saturday when the mail is delivered the CNA or designated employee will sort the mail and deliver it to the cottages. The cottage CNA or Nurse will deliver the mail directly to the veterans. 4) An audit will be performed each Monday to ensure the mail was delivered on Saturday for 3 months. During Quality assurance the audits will be reviewed for compliance for the previous month. The plan will be adjusted as needed to reach this goal. 5) Weekly audits will be performed on mail delivery; these audits will be assessed monthly during quality assurance for 3 months with a completion goal of 8/28/2024.	Completed 8/28/2024

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F 576	Continued From page 4 video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure mail delivery, including on Saturdays. The census was 18. The findings were: 1. Interview with 4 residents during resident council on 7/24/24 at 2:00 PM revealed they did not receive mail on Saturdays. 2. Interview with the activities director on 7/25/24 at 10:49 AM confirmed that mail was not delivered on Saturdays. 3. Interview with the activities director on 7/26/24 at 8:30 AM revealed there was no policy regarding mail delivery.	F 576		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585	F0585-Grievances 1) This facility acknowledges that the resident have a right to information on how to file a grievance or complaint available, we also acknowledge the resident right to prompt resolution of any complaints or grievances. The survey Identified resident #15 had grievances that were not reported or addressed and this Facility had failed to provide information to the veterans on how to file a grievance. Resident #15 was interviewed and all grievances were investigated. Grievance 1 missing watch. Staff had not been made aware of missing watch until the 7/25/24, grievance form was filled out with the veteran regarding the missing watch and the veteran's room was searched with the resident #15's approval and the watch was located.	Completed 8/28/2024

Grievance a. Resident #15 requesting to speak with wife via phone. Staff were educated on resident rights. Grievance b. Resident #15 voiced a resident from the assisted living was taking advantaged of him/her. This grievance had already been addressed but, follow-up documentation was not in the residents chart. The resident had bought a phone when living in the veteran's home of Wyoming Assisted Living facility from another resident and then moved to the skilled nursing facility. The phone was not working and the veteran wanted his/her money back. Do to the transaction happening prior to admission and outside of this facility, and the purchase of the phone was a private transaction this facility was not able to obtain refund for Resident #15. The resident from the assisted living was asked not visit resident #15 per his/her request. Documentation of this was completed late on grievance form per social services. Grievance c. Resident #15 feeling like they are not a priority and staff not changing sheets. Staff where provided with education on address veterans with kindness and respect as well as follow through on tasks at staff meeting on 8/26/24 and 8/28/24. One on one conversation also had with Resident #15 per social worker regarding reporting process of any concerns or grievances.

2) All 18 veterans presently living in facility were not aware of how to report a grievance and forms were not readily available to them. Chart audits were performed on all 18 veterans to assess for any documentation of grievances that had not been addressed. Resident #15 was the only Resident Identified with documented grievances and all have been addressed and resolved to the resident's satisfaction at this time.

3) Grievance forms have been placed in the public space of each cottage accessible to staff, visitors, and veterans. All 18 veterans presently living in this facility have had one on one education on how to report a grievance and the location of grievance forms. The staff have all been educated on the policy, process/procedure and the location of grievance forms with verified

			competency. Policy has been updated to include weekly assessment of all grievances and there resolution with grievance committee. A process has also been established to assess for grievances during care conference. Questions to be asked during each care conference include: has the veteran received education regarding reporting a grievance including how to do so, location of forms, and who they may report to? And has the veteran had any unresolved grievance? And a description of the grievance if they have. Implementation of new admission assessment and admission check sheet to include education regarding how to report a grievance and the location of the grievance forms. Education added to the orientation process to ensure staff understanding of the grievance process. 4) Monthly audits of the care conferences notes, new admissions, and new staff orientation will be completed to assess for compliance with education and resolution of grievances. Weekly committee meetings will take place to audit appropriate, prompt resolution of grievances. During Quality assurance the audits will be reviewed for compliance for the previous month. With a goal of 100%. The plan will be adjusted as needed to reach this goal. 5) Audits will be completed monthly and weekly these audits will be assessed at Quality Assurance for 3 months with a completion date of 8/28/2024.	

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F 585	Continued From page 5 facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 585		

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F 585	Continued From page 6 conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the	F 585		

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Result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure prompt resolution for 1 of 1 sample residents (#15) with grievances. In addition, the facility failed to ensure information on how to file a grievance or complaint was available to all residents. The census was 18. The findings were:

1. Interview with resident #15 on 7/25/24 at 12:34 PM revealed the facility did not follow up on concerns. The resident revealed s/he had voiced concerns about staff and missing items; however, nothing had been done. Further interview revealed s/he recently notified staff about a missing watch. The following concerns were identified:

a. Review of a progress note dated 4/19/24 and timed 11:37 AM showed the resident asked a staff member to contact his/her spouse to inform them s/he wasn't feeling well. The progress note indicated the staff member told the resident staff were serving lunch and they did not know what the policy was on calling family unless it was an emergency or health concern. Further review showed the resident became agitated and the staff member stated "do not cuss at me I am here to help you with appropriate tasks." Review of a progress note dated 4/19/24 and timed 12:35 PM showed the CNA notified the nurse of the resident's "aggressive behavior" and the nurse discussed the behavior with the resident. Further review showed the resident verbalized concerns about the staff member and stated "She is always

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telling me what to do and we don't get along." Further review showed no evidence a grievance form was completed or follow-up to the resident's concerns was performed.

b. Review of a progress note dated 4/21/24 and timed 4:28 AM showed the resident verbalized concerns about a resident from the assisted living "taking advantage" of him/her over a cell phone. The resident requested to speak to management about the concerns and was told the DON was not at the facility on Sundays. Further review showed the writer indicated they would notify the DON as soon as possible; however, there was no evidence a grievance form was completed or follow-up to the resident's concerns was performed.

c. Review of a progress note dated 6/30/24 and timed 9:34 AM showed the resident reported s/he attempted to get assistance from staff "multiple times last night" and staff did not assist him/her. The resident acknowledge staff did assist when s/he had an episode of diarrhea. Review of a progress note dated 6/30/24 and timed 1:18 PM showed the resident requested his/her bedding be changed and staff indicated they would come back and take care of it when they finished other tasks. At 1:20 PM the resident rang the call light and told staff s/he "doesn't get taken care of well here." The CNA asked why the resident felt that way and the resident indicated s/he "sits and waits forever and no one helps [him/her]. [S/he] wanted [his/her] bed changed and no one will take care of it." The CNA confirmed the bedding had not been changed and told the resident they were in the middle of helping another resident with "important personal cares." The resident stated "I know everyone is more important than me." Further review showed the CNA replied "no you are important and if you

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F 585	Continued From page 9 Need something that is time sensitive then we will help you but making your bed compared to multiple call lights for personal cares are going to come first and then your bed will be handled." Review of a progress note dated 6/30/24 and timed 1:48 PM showed the staff member asked the resident at 11:15 AM if s/he was coming out for lunch and the resident said no. The staff member asked if the resident wanted the meal brought to his/her room and resident declined. The resident called after lunch and asked the CNA why they didn't get him/her for lunch and asked for his/her bed to be made. The resident indicated s/he was told staff would return to make his/her bed and they had not. The resident stated "I am being forgotten, I am not a priority." The progress note showed "Resident was educated and was told that staff would return as soon as they got done toileting another resident. Call light was within reach of patient. [S/He] does not have any other complaints or needs at this time." Further review showed no evidence a grievance form was completed or follow-up to the resident's concerns was performed. 2. Observation during the course of the survey from 7/23/24 through 7/26/24 showed no evidence of postings related to the grievance procedure or grievance official. 3. Interview with 4 residents during the resident council meeting on 7/24/24 at 2:00 PM revealed all were not aware of the grievance process, how to file a grievance, or who the grievance official was. 4. Interview with RN #2 on 7/25/24 at 11:49 AM revealed staff initiated the grievance process by filling out a form and providing it to the DON or	F 585		

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business office personnel. Further interview revealed the forms were not available to the residents.

5. Interview with RN #3 on 7/25/24 at 12:04 PM confirmed staff initiated the grievance process by filling out a form and providing it to the DON or business office personnel. Further interview revealed the forms were not available to the residents.

6. Interview with the DON on 7/24/24 at 2:56 PM revealed the residents received the information about the grievance process in the admission paperwork; however, she revealed "some of them probably do not remember they got it."

7. Interview with the DON on 7/25/24 at 8:20 AM revealed the facility had not received any resident grievances and "they can let the staff know if they have a grievance." Further interview revealed the grievance process included the completion of a form; however, she confirmed the form was not available to the residents.

8. Interview with the DON on 7/25/24 at 3:57 PM confirmed the concerns voiced by resident #15 should have been written up as a grievance; however, it was revealed the information was not communicated to the leadership team.

9. Review of policy titled "Grievance" last revised
12/4/23, showed " ... the community will inform Veterans orally and in writing of their rights to make Complaints and Grievances and the process to do so during admission, readmission and the care planning process. The notice shall include information on how to file a grievance orally or in writing, the right to file anonymously,

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	WY9071	A. BUILDING _____ B. WING _____	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING VETERANS' SKILLED NURSING FACILITY	700 VETERANS' LANE BUFFALO, WY 82834

(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 585	Continued From page 11 and the community designated Grievance Official/Social Worker"	F 585		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.(iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732	F0732-Posted Nurse Staffing information 1) This facility acknowledges it is our responsibility to nurse staffing was posted in a prominent location which was accessible to residents. The Nurse staffing information was posted in the Breezeway of each cottage which, may not be easily accessible to all veterans. The Nurse staffing posting was immediately moved to the main lobby area in a location easily seen by all. The form was also updated to a large print more visible to the veterans. 2) All 18 veterans presently living in the facility were impacted by this find. 3) Daily nursing staffing moved from breezeway to public space visible to all veterans. Staffing form made with larger print to make easier for the veterans to see. Staff education preformed on 8/26 and 8/28, on visibility and new form. 4) Daily audits will be performed to ensure form is visible to veterans. Monthly during Quality assurance the audits will be reviewed for compliance for the previous month. With a goal of 100%. The plan will be adjusted as needed to reach this goal. 5) Audits will be completed daily these audits will be assessed monthly at Quality Assurance for 3 months with a completion date of 8/28/2024.	Completed 8/28/2024

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F 732	Continued From page 12 Posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nurse staffing was posted in a prominent location which was accessible to residents. The census was 18. The findings were: 1. Observation on 7/25/24 at 9:19 AM showed the daily nurse staff postings were located in the breezeway of each cottage. 2. Interview with the DON at that time revealed residents may not be able to access the area to review the information.	F 732		
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 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	F 758	F0758-Free from Unnec Psychotropic meds/ PRN use 1) This facility recognizes that it is our responsibility to ensure target symptoms and nonpharmacological interventions are identified and monitoring of target symptoms is taking place for all residents receiving psychotropic medications. The survey ID Resident #12, #3, #4, and #15 had missing monitoring for specific target symptoms for psychotropic medications and no resident specific non-pharmacological interventions were on MAR, TAR or Care Plan. Chart reviews and audits were performed on each Resident chart, and Resident specific target symptoms where added for each psychotropic medication on the TAR and Care plan. Chart audits were completed on each resident to add Resident specific non-pharmacological interventions to the TAR and care plan. Survey identified that resident #4 had citalopram monitoring on	Completed 8/28/2024

			the TAR but there was no order for citalopram. This was entered on TAR in error. The Citalopram was removed from the TAR. 2) All 18 veterans presently living in the facility had charts reviewed for Psychotropic medications, and Resident specific target symptoms and non-pharmacologic interventions, where added for each psychotropic medication on the TAR and Care plan. 3) Chart audits will occur on admission with initial care conference to ensure needed target symptom monitoring and non-pharmacological interventions are implemented in the care plan and TAR. The Target symptoms will have a quantitative value that will be reviewed by the physician along with BIMS and PHQ-9 score to assess for appropriate and safe GDR attempts. The appropriateness of the target symptoms and interventions will be audit quarterly with care conference, and changes needed will be addressed. 4) The target symptoms and interventions will be audited on admission and quarterly. These audits will be discussed and reviewed monthly at the psy/pharm portion of the Quality assure meeting. 5) Audits from admissions and quarterly care conference will be assessed monthly at Quality Assurance for 3 months with a completion date of 8/28/2024.	

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F 758	Continued From page 13 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 medical record review, staff interview, and policy and procedure review, the facility failed to ensure target symptoms and nonpharmacological interventions were identified and monitoring of target symptoms was completed for 4 of 6 sample residents (#3, #4, #12, #15) reviewed for unnecessary psychotropic medications. The findings were:	F 758		

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F 758	Continued From page 14 1. Review of the admission MDS assessment dated 5/20/24 showed resident #12 had a brief interview for mental status score of 14, which indicated s/he was cognitively intact, and diagnoses which included schizophrenia. Review of the physician orders showed the resident received lithium carbonate (mood stabilizer) 300 milligrams (MG) by mouth two times a day for bipolar disorder related to schizoaffective disorder, depressive type, topiramate (anticonvulsant) 150 mg by mouth two times daily for tremors, and olanzapine (antipsychotic) 5 mg by mouth at bedtime for psychosis/mood related to schizoaffective disorder, depressive type. The following concerns were identified: a. Review of the medication administration record for May, June, and July 2024 showed no evidence the facility identified resident specific target symptoms for each medication or a process to monitor specific target symptoms. b. Review of care plan, last revised on 05/21/24, showed a targeted behavior of yelling out due to hallucinations; however, the care plan did not identify which medication was used for treatment, did not identify medication specific target symptoms for all psychotropic medications, and did not identify resident specific non-pharmacological interventions. c. Review of the behavior monitoring on the treatment administration record for May, June, and July 2024 showed "monitor for any behavior outside of [his/her] normal." Further review showed no evidence the facility identified resident specific target symptoms for each medication or a process to monitor resident specific target symptoms. 2. Review of the admission MDS assessment dated 5/13/24 showed resident #3 had a brief	F 758		

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F 758	Continued From page 15 interview for mental status score of 15, which indicated the resident was cognitively intact, and diagnoses which included depression and schizophrenia. Review of the physician orders showed the resident received, Risperdal (antipsychotic) 0.5 MG by mouth two times a day for psychosis/neurocognitive behaviors related to unspecified behavioral and emotional disorders, bupropion (antidepressant) 150 MG extended release by mouth in the morning for depression related to major depressive disorder, lurasidone (antipsychotic) 40 MG by mouth in the morning for psychosis/mood related to unspecified behavioral and emotional disorders, mirtazapine (antidepressant) 7.5 MG by mouth at bedtime for depression related to schizoaffective disorder, and abilify (antipsychotic) 15 MG by mouth at bedtime for mental health related to unspecified behavioral and emotional disorders. The following concerns were identified: a. Review of the care plan last revised on 6/19/24 showed no evidence the facility identified resident specific target symptoms for each medication or resident specific non-pharmacological interventions. b. Review of the medication administration record for May, June, and July 2024 showed no evidence the facility identified resident specific target symptoms for each medication or a process to monitor resident specific target symptoms. c. Review of the behavior monitoring on the treatment administration record for May, June, and July 2024 showed "monitor for any behavior outside of [his/her] normal." Further review showed no evidence the facility identified resident specific target symptoms for each medication or a process to monitor resident specific target symptoms.	F 758		

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F 758	Continued From page 16 3. Review of the care plan last revised on 6/14/24 showed resident #4 had diagnoses which included post-traumatic stress disorder, anxiety disorder, alcohol dependence with alcohol-induced persisting dementia, other psychoactive substance dependence, and dementia with behavioral disturbance. Review of the physician's orders showed the resident received olanzapine (antipsychotic) 5 mg by mouth daily for dementia with behavioral disturbance, sertraline (antidepressant) 50 mg by mouth daily for depressive disorder, and hydroxyzine (antihistamine) 25 mg by mouth for post-traumatic stress disorder. The following concerns were identified: a. Review of the care plan last revised on 6/14/24 showed no evidence the facility identified resident specific target symptoms for each medication or resident specific non-pharmacological interventions. b. Review of the medication administration record for May, June, and July 2024 showed "Veteran uses medications Zoloft (olanzapine), Zyprexa (sertraline), and citalopram (Celexa) r/t [related to] depression or dementia. Monitor for s/s [signs and symptoms] of depression or dementia and notify MD for any concern..." Further review showed no evidence the facility identified resident specific target symptoms for each medication or had a process to monitor resident specific target symptoms. In addition, there was no evidence the resident had an order for citalopram. 4. Review of the care plan last revised on 7/22/24 showed resident #15 had diagnoses which included nightmare disorder, post-traumatic stress disorder, alcohol dependence, unspecified psychosis not due to a substance or known	F 758		

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F 758	Continued From page 17 physiological condition, and bipolar disorder. Review of the physician's orders showed the resident received trazodone (antidepressant) 100 MG by mouth at bedtime related to insomnia, buspirone (antianxiety) 10 mg by mouth 3 times per day for bipolar disorder, fluoxetine (antidepressant) 10 mg by mouth daily for post-traumatic stress disorder, and lamotrigine (anticonvulsant) 200 mg by mouth daily at bedtime for bipolar disorder. The following concerns were identified: a. Review of the care plan last revised on 7/22/24 showed no evidence the facility identified resident specific target symptoms for each medication or resident specific non-pharmacological interventions. b. Review of the medication administration record for May, June, and July 2024 showed no evidence the facility identified resident specific target symptoms for each medication or had a process to monitor resident specific target symptoms. 5. Interview with the DON on 7/25/24 at 5:23 PM confirmed the facility had not identified resident specific target symptoms for psychotropic medications and had not identified resident specific non-pharmacological interventions. 6. Review of policy titled "Psychotropic Medication Use" last revised 1/1/22 showed " ... the facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behavior..."	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals	F 761	F0761 Label/store Drugs and Biologicals 1) This facility acknowledges that it is our responsibility to ensure medications available for resident use	Completed 8/28/2024

				are not expired. 2 vials of Aplisol tuberculin protein derivative where found to be expired in the medication refrigerator in cottonwood cottage. Both where immediately discarded. 2) An audit of all medications in facility including the medication cabinets in veteran's rooms, the medication cart, and the medication refrigerators was performed and no further expired medications were located. 3) Weekly medication audits implemented to monitor medications storage and medication expiration. These audits will be performed by the dayshift and nightshift floor nurses and correction action taken immediately with any findings. Education was provided to all nursing staff on 8/26/2024 and 8/28/2024 on the medication audit process and competency was verified. 4) The weekly audits will be reviewed at the monthly quality assure meeting to verifying that corrective actions were taken to ensure no medication that are expired are left available to administer to the veterans. The plan will be adjusted as needed to ensure compliance. 5) Audits will be reviewed monthly for 3 months, with a goal completion date of 8/28/24	

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F 761		F 761		

Continued From page 18
CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on, observation, staff interview, and policy review the facility failed to ensure medications available for resident use were not expired in 1 of 2 storage rooms (Cottonwood Cottage). The findings were:

1. Observation of the Cottonwood cottage medication storage room refrigerator on 7/23/24 at 5:36 PM showed a vial of Aplisol tuberculin protein derivative with an open date of 5/15/24

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F 761	Continued From page 19 and an Aplisol tuberculin protein derivative with an open date of 7/23/24. Review of the manufacturer's literature indicated vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. Interview with LPN #1 at that time revealed the infection prevention nurse was responsible for the vials and she would need to ask her about the vials. 2. Interview with LPN#1 on 7/23/24 at 6:00 PM revealed the infection prevention nurse confirmed the vials were expired and should have been discarded. 3. Review of the policy titled "Storage and Expiration Dating of Medications, Biologicals" last revised on 8/7/23 showed " ...If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial ..." 4. Interview with the infection preventionist on 7/24/24 at 2:40 PM confirmed the tuberculin vials should have been discarded. 5. Interview with LPN #2 on 7/26/24 at 8:14 AM revealed all medications stored in the medication storage room refrigerator were available for resident use.	F 761		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806	F0806 Resident Allergies, Preferences, Substitutes 1) This facility recognizes that the residents have the right to accommodation of resident preference. Resident #17 has a preference of cut up foods and the staff did not check the preference on the tablet prior to serving. Immediate verbal staff education was completed with an in depth visual training occurring on 8/26/24 and 8/28/24.	Completed 8/28/2024

2) Chart audits were completed on all 18 veterans presently living in the facility to verify diet order and veterans preferences where in the chart and accessible to all pertinent staff.
3) All 18 veterans presently living in the facility have an updated diet order and preference listed in their charts that is accessible to pertinent staff. Staff had in depth visual demonstration education and were verified as competent on how, when, and where to check veterans diet and preferences.
4) Random weekly audits will take place at meal times to verify staff compliance with checking diets and preferences. If staff are found to be non-compliant reinforcement of education will take place. Diet and preferences will be assessed quarterly at care conference and PRN with each veteran. Monthly during Quality assurance the audits will be reviewed for compliance for the previous month. With a goal of 100%. The plan will be adjusted as needed to reach this goal.
5) Audits from weekly audits and quarterly care conference will be assessed monthly at Quality Assurance for 3 months with a completion date of 8/28/2024.

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	700 VETERANS' LANE

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F 806	Continued From page 20 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure accommodation of resident preferences for 1 of 3 sample residents (#17). The findings were: 1. Review of the diet order for resident #17 showed the resident had a preference for food to be cut up. The following concerns were identified: a. Observation on 7/24/24 at 5:06 PM showed the resident was served scrambled eggs and kielbasa sausage in slices and became angry due to the eggs being scrambled and s/he wanted link sausage instead of kielbasa sausage; however, staff stated links were not available. Further observation showed the resident had to pull the casing off of sausage in order to eat it. b. Observation on 7/25/24 at 11:17 AM showed CNA #1 was preparing meal trays and verified what option each resident wanted for that day by looking at a hand written note on an erasable white board. Interview with the CNA at that time revealed the resident's diet order and preferences were on the care plan; however, the facility did not have a way to verify the information during meal service. c. Interview with the DON on 7/25/24 at 11:55 AM revealed a tablet was available for staff to identify which residents have a modified diet and the diet should be checked every day before meal service.	F 806		

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F 806	Continued From page 21 d. Interview with the dietary manager on 7/25/24 at 2:57 PM revealed staff should have modified meals per the information from the resident's record and staff should follow preferences when providing meals. e. Interview with the dietitian on 7/26/24 at 8:47 AM revealed at that time, all resident diets were regular texture; however, some residents liked ground or softer foods. The dietitian revealed staff should cut resident meals with the ninja robo coup and should verify diets and preferences prior to serving.	F 806		