PRINTED: 10/12/2017
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 09/28/2017

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

11/3/17

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 9/27/17 through 9/28/17. The survey was prompted by complaint intake WY000002486. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with the federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in an accordance with the state operations manual.	
F 201 SS=D	483.15(c)(1)(i)(ii) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT (c) Transfer and discharge (1) Facility requirements (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 201	1. Resident #4 no longer resides in the facility. Resident #1 still resides in the facility. Resident #1 will not be discharged or transferred while awaiting the discharge appeal, unless identified and documented as an immediate health or safety risk. 2. There are currently no other residents in the facility that have received a notice of the facility's intent to discharge and have requested an appeal. 3.The facility's Executive Director will review and update the language contained within future notices (those with respect to endangered health and safety of other residents). The language will be strengthened (pragmatically) to include "failure to discharge or transfer would endanger the health and safety of the resident and other individuals in the facility". If the facility is convinced that the discharged patient does not pose a threat to the safety of other individuals in the facility, the patient will be readmitted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/2/17

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.

RECEIVED
NOV 02 2017
Healthcare Licensing and Surveys

11/3/17 Plan of correction accepted. Alyssa Renneisen notified at 2:40 PM. Date of correction is 10/27/17. Julie VanDyke

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F 201	Continued From page 1 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 2 sample residents (#4) were not discharged or transferred while awaiting a discharge appeal and not identified as an immediate health or safety risk. The findings were: 1. Review of the 9/22/17 quarterly MDS	F 201	In addition, in future instances where the facility's Interdisciplinary Team has assessed a patient to pose a danger to themselves or others, the facility Executive Director will review the medical record to ensure said emanate danger is assessed by the interdisciplinary team, that then will develop meaningful interventions to address the resident's needs. Facility staff will be trained to implement these interventions, the success or failure of the interventions will be monitored and the process will be repeated as necessary. In this circumstance, the proof that a discharge is unavoidable will exist in the medical record. The facility will ensure any resident(s) that receive an intent to discharge notice are not discharged or transferred while awaiting a discharge appeal, unless the discharge is documented as unavoidable in their medical record. The facility will identify these resident(s) on their "discharge" care plan.	

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F 201	Continued From page 2 assessment showed resident #4 had diagnoses which included non-Alzheimer's dementia, depression, and frontotemporal dementia. Review of the 9/22/17 discharge MDS assessment showed the resident was discharged on 9/21/17. The discharge was not planned and return was not anticipated. The following concerns were identified: a. Review of a discharge notice dated 8/4/17 showed the facility issued an intent to discharge notice to the resident's spouse related to "safety and/or well-being of individuals in the facility." The discharge should be considered "immediate which means, as soon as practicable." Further review showed the letter contained information about the resident's right to appeal discharge or transfer. b. Review of a letter from the resident's spouse dated 8/10/17 showed the family had requested an appeal of the discharge. c. Review of a discharge notice dated 9/6/17 showed the facility issued an intent to discharge notice to the resident's spouse related to the facility's "secured unit closure, effective October 5th, 2017." Further review showed the letter contained information about the resident's right to appeal discharge or transfer. d. Review of a social services note dated 9/21/17 and timed 7:38 PM showed staff had reported the resident kicked CNA #1 in the left knee at "around" 4:30 PM. Following the incident the resident "returned to baseline quickly." The police, primary physician, on-call physician, medical director, and the resident's family member were notified. e. Review of a physician record of visit dated 9/21/17 and untimed showed the resident had frontotemporal dementia, intermittent outbursts of aggressive behaviors, and an inconsistent sleep	F 201	An audit was completed on October 18, 2017, and as needed after that, by the Executive Director or designee to ensure any resident(s) awaiting a discharge appeal is not discharged or transferred, unless the discharge is documented as unavoidable in the medical record. A (Teepa Snow) dementia training has been provided in October to staff, including handouts and a 2.5 hour video with information, tips, and techniques on "Challenging Behaviors in Dementia Care: Recognizing and Meeting Unmet Needs." 4. The results/ findings of the audit(s) will be reviewed at each of the facility's Performance Improvement Committee meetings. Note: The facility's QAPI meetings consist of (at least) the facility's Executive Director, Medical Director, Director of Nursing, and Director of Social Services. Other attendees as applicable and appropriate. The committee reviews at a minimum, and continually, internal audits of facility systems, facility policies, compliance issue(s), other Quality Measures, et. al. If the committee recognizes a problematic trend(s) within any of the review(s), the committee or a subcommittee is assigned to create and implement an action plan designed specifically to mitigate the outlying trend. Subsequent meetings review the results of the action plan(s). 5. Compliance met on or before October 27, 2017.	10/27/2017

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F 201	Continued From page 3 pattern in which the resident "may go" more than 36 hours without sleep. Further review showed the medical director increased the resident's Zyprexa (antipsychotic) to 20 milligrams (mg) by mouth every evening at hours of sleep and to continue to work on transfer to a facility that could "better meet [his/her] need." f. Review of the "physician interim orders" sheet dated 9/21/17 and timed 6:15 PM showed the medical director ordered the resident to be transferred "either by officer or ambulance" to the ER (emergency room) for evaluation related to a diagnosis of "frontal temporal lobe dementia with violent unprovoked outburst assaulting staff and residents." g. Review of an "ER Admission Report" dated 9/21/17 and untimed showed the resident presented to the emergency department via police escort secondary to episodes of aggression. The resident's primary care physician had contacted the ER to notify them the resident had an order for "do not transport except for palliative management." The ER physician documented the resident was "cooperative" and although the physician had ordered Haldol to be administered as needed for agitation, it was never required. Further, the report showed the resident's family wanted the resident to return to the nursing facility; however, the physician had discussed return with the nursing facility's administrator and was told the facility was "unwilling to take their patient back." h. Review of a hospital physician's note dated 9/21/17 and timed 8:10 PM showed the physician spoke to the facility about the resident and the facility requested the resident be transferred to the hospital via the police or ambulance and placed on a hold. The physician did not agree with either option and instructed the facility to	F 201		

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F 201	Continued From page 4 "hold off" on action until the physician could discuss the situation with his/her attending physician. Further, the physician's note showed the physician attempted to call the facility back; however, the staff member the physician had been communicating with was no longer at the facility. The physician left a message for the facility "not to transport" the resident. I. Review of a hospital physician's note dated 9/21/17 and timed 10:51 PM showed the resident was medically cleared by the ER physician and could return to the facility; however, the facility "refused readmission and thus abandoned the patient" resulting in the resident being admitted to the hospital. J. Interview with CNA #1 on 9/28/17 revealed the resident kicked him on 9/21/17 and was discharged following the incident. Further, the CNA revealed he did not think the incident was "that bad", and the resident "returned to normal" following the incident. K. Interview with the administrator, DON, and social services director on 9/28/17 at 11:06 AM confirmed the resident was discharged on 9/21/17 by the facility's medical director and would not be accepted back to the facility. Continued interview revealed the police officer was at the facility for two hours prior to the discharge and could not take the resident until a physician order was obtained since the resident had returned to baseline. Further, it was confirmed the resident had been issued two discharge notices previously, an appeal was pending at the time of transfer, and it was not normal practice for the facility to refuse to allow a resident to return to the facility following a hospital transfer. L. Interview with the long term care ombudsman on 10/6/17 at 11:20 AM revealed the	F 201		

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F 201	Continued From page 5 resident had been transferred to another skilled nursing facility that did not have a secured unit. Further, she was not aware of any additional services that would be provided by the facility the resident was transferred to.	F 201		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 203	1. Resident #4 no longer resides in the facility. 2. Any resident who is involuntarily transferred or discharged and provided a notice as as specified by the regulations. 3. Policy and procedure reviewed/updated to reflect the requirements that all residents who are involuntarily transferred or discharged will have received a notice as specified in the regulations. Furthermore, the notice will include all required elements. Staff training will reflect the regulatory requirements. The facility Executive Director (or her designee) will review, or log, each involuntary transfer or discharge effectuated by a notice to ensure that it meets regulations. 4. The results of the aforementioned log will be reviewed at each of the facility's Performance Improvement Committee meetings, as applicable. 5. Compliance met on or before October 19, 2017.	10/19/2017

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F 203	Continued From page 6 (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 203		

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F 203	Continued From page 7 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §	F 203		

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F 203	Continued From page 8 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to update or issue a new notice before a transfer or discharge for 1 of 1 sample resident (#4) who was not allowed to return to the facility. The findings were: 1. Review of the 9/22/17 quarterly MDS assessment showed resident #4 had diagnoses which included non-Alzheimer's dementia, depression, and frontotemporal dementia. Review of the 9/22/17 discharge MDS assessment showed the resident had an un-planned discharge on 9/21/17 and return was not anticipated. The following concerns were identified: d. Review of a social services note dated 9/21/17 and timed 7:38 PM showed staff had reported the resident kicked CNA #1 in the left knee at "around" 4:30 PM. Following the incident the resident "returned to baseline quickly." The police, primary physician, on-call physician, medical director, and the resident's family member were notified. f. Review of a "physician interim orders" sheet dated 9/21/17 and timed 6:15 PM showed the medical director ordered the resident to be transferred "either by officer or ambulance" to the ER (emergency room) for evaluation related to a diagnosis of "frontal temporal lobe dementia with violent unprovoked outburst assaulting staff and residents." g. Review of an "ER Admission Report" dated 9/21/17 and untimed showed the resident presented to the emergency department via police escort secondary to episodes of aggression. The resident's primary care physician	F 203		

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F 203	Continued From page 9 had contacted the ER to notify them the resident had an order for "do not transport except for palliative management." Further, the resident's family wanted the resident to return to the facility; however, the physician had discussed return with the facility's administrator and was told the facility was "unwilling to take their patient back." h. Review of a hospital physician's note dated 9/21/17 and timed 8:10 PM showed the physician spoke to the facility about the resident and the facility requested the resident be transferred to the hospital via the police or ambulance and placed on a hold. The physician did not agree with either option and instructed the facility to "hold off" on action until the physician could discuss the situation with his/her attending physician. Further, the physician's note showed the physician attempted to call the facility back; however, the staff member s/he had been communicating with was no longer at the facility, and the physician left a message for the facility "not to transport" the resident. I. Review of a hospital physician's note dated 9/21/17 and timed 10:51 PM showed the resident was medically cleared by the ER physician and could return to the facility; however, the facility "refused readmission and thus abandoned the patient" resulting in the resident being admitted to the hospital. k. Interview with the administrator, DON, and social services director on 9/28/17 at 11:06 AM revealed an updated or new discharge notice that included the reason for discharge or transfer was not issued at the time the resident was transferred to the hospital on 9/21/17.	F 203		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353	1. Resident #4 no longer resides in facility.	

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F 353	Continued From page 10 483.35 Nursing Services 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 §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (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. (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. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as	F 353	2. A 100% Care Plan audit was conducted on October 18, 2017 by the facility's Executive Director and/or designee. No other care plans reference the assessed need for 1 to 1 supervision. 3. Going forward, if the facility's care plan team assesses a patient's need for 1 to 1 supervision, the facility will provide the supervision without the assistance of the family/interested party. Moving forward, new hires, in the nursing department, will complete the Challenging Behaviors in Dementia Care: Recognizing & Meeting Unmet Needs" training. 4. The results/ findings of the audit will be reviewed at each of the facility's Performance Improvement Committee meeting. 5. Compliance met on or before October 19, 2017.	10/19/2017

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING _____ B. WING _____	C 09/28/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 11 identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility staffing records, and staff interview, the facility failed to ensure adequate staffing to ensure resident safety for 1 of 1 sample resident (#4) who required 1 to 1 supervision. The findings were: 1. Review of the 9/22/17 quarterly MDS showed resident #4 had diagnoses which included non-Alzheimer's dementia, depression, and frontotemporal dementia. The following concerns were identified: a. Review of nursing note dated 8/2/17 and timed 1:54 PM showed resident #4 was found in another resident's room and the nurse observed the resident punching the other resident. Resident #4 was placed on one-on-one supervision. b. Review of a social services note dated 8/7/17 and timed 9:07 AM showed the resident's significant other was contacted related to the one-on-one for the resident. The note showed social services explained the "facility policy" was to "assist with 1:1 [one-to-one] for 72 hours following a physically aggressive episode. After the 72 hours [the facility] would need [him/her] to provide that service [him/herself] or find someone to help. [The facility] asked [spouse's name] to provide a schedule of [his/her] availability so that [the facility] could plan staffing accordingly.	F 353		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535049	A. BUILDING _____ B. WING _____	0 09/26/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 12 [Spouse's name] did not provide the information until Monday morning. [Spouse's name] has been uncooperative with finding alternate placement and providing 1:1 services as requested. [The facility] spoke with [spouse's name] again this morning and asked [her/him] specifically when [s/he] is working..." Further, the note showed "... [S/he] stated that [s/he] could not afford to hire anyone to come during those times. [The facility] informed [him/her] that 1:1 services are not something [the facility] can continue to provide. [Spouse's name] stated "Ok well I have to let my dogs out now because they are suffering too because of this. Then I will be up there." [Social services director] and [administrator] notified of [his/her] inability to provide 1:1 services during the requested times..." c. Review of a social services noted dated 9/13/17 and timed 12:02 PM showed police were contacted the previous day related to an altercation during which the resident punched a staff member. Further review showed "...On 9/13/17 social services approached [spouse's name] with a letter clearly stating the times in which she agreed to be in the facility to provide 1:1 care with [resident's name]. Social Services explained that this letter was simply to ensure that staff would be provided for the 1:1 outside of the times [spouse's name] was available. [Spouse's name] stated that [s/he] was "just going to be here all the time." Social Services explained that we as a facility understand that it is not reasonable to be here 24/7 and that outside of [his/her] original times staff would be here and if [s/he] chose to stay it would be considered [his/her] time as a visit and voluntary..." d. Review of the "daily staffing sheets" from 8/2/17 to 9/21/17 showed the facility identified the resident needed one-on-one care between 8 AM	F 353		

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

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F 353	Continued From page 13 and 8 PM. No one-on-one care was provided from 8 PM to 8 AM. Further review showed the resident's spouse was scheduled to provide the care from 8 AM to 8 PM on 8/19, 8/22, 8/26, 8/27, 8/29, 9/9, and 9/10. There was no identified one-on-one caregiver for at least part of the 8 AM to 8 PM identified time period on 22 out of 60 days. e. Interview with the administrator, DON, and social services director on 9/28/17 at 11:48 AM confirmed the resident required one-to-one care related to safety of the resident and others; however, the facility did not have a policy for one-to-one services. Further interview revealed the facility scheduled the resident's spouse to provide one-to-one care for the resident, the spouse was not a facility employee or compensated for the care provided, and facility staff was not scheduled to provide care when the spouse was at the facility. The interview revealed the facility would need to add additional positions to ensure adequate one-to-one services for the resident and they had not applied for the Medicaid extraordinary care rate to do so. Further, the facility did not provide any education to the spouse regarding the resident's behaviors, interventions, or re-direction to prevent incidents from occurring.	F 353		