STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	635021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 1/26/15 through 1/29/15. In addition, a complaint investigation was done prompted by complaint intake WY00001827. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set CAA: Care Area Assessment MAR: Medication Administration Record POA: Power of Attorney Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	Resident #20, #25, and #23 rooms and the activity room were checked to make sure the curtains were appropriate for the doorway. Each curtain was checked for these rooms to ensure they fit the doorway, reached across, and are in good repair. All nursing staff were trained on privacy and the use of curtains. . All residents could potentially be affected. . Staff were trained and educated on patient privacy while providing resident care. Staff were trained on the proper utilization of privacy curtains. Training was completed on 2/17/15 - 2/18/15. Annual orientation will include patient privacy while providing resident care. .	03/15/15

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

NHA 3-20-15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 1/26/15 through 1/29/15. In addition, a complaint investigation was done prompted by complaint intake WY00001827. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set CAA: Care Area Assessment MAR: Medication Administration Record POA: Power of Attorney Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	Resident #20, #25, and #23 rooms and the activity room were checked to make sure the curtains were appropriate for the doorway. Each curtain was checked for these rooms to ensure they fit the doorway, reached across, and are in good repair. All nursing staff were trained on privacy and the use of curtains. . All residents could potentially be affected. . Staff were trained and educated on patient privacy while providing resident care. Staff were trained on the proper utilization of privacy curtains. Training was completed on 2/17/15 - 2/18/15. Annual orientation will include patient privacy while providing resident care. .	03/15/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure privacy was maintained during personal care for 2 of 13 sample residents (#23, #25) and one non-sample resident (#20). The findings were: 1. Observation on 1/27/15 at 8:55 AM showed resident #25 was assisted to the bathroom in the resident's room by CNA #6 and CNA #7. The resident was assisted with removal of his/her clothes and brief. There was no door to the resident room, and the privacy curtain was not pulled. The resident was unclothed from the waist down and visible from the hallway. 2. Observation on 1/27/15 at 11:45 AM showed resident #23 was assisted to the bathroom in the resident's room by CNA #6. The resident was assisted with removal of his/her clothes and brief. There was no door to the resident's room, and the privacy curtain was not pulled. The resident was unclothed from the waist down and visible from the hallway. Interview at that time with the	F 164	The privacy curtain in the activity room was repaired by Environmental Services on 1/28/15. . All rooms will be checked to ensure appropriate barriers are in place to protect all resident's privacy. . Environmental Services is responsible for checking curtains throughout the facility. . The integrity and proper repair of barriers will be monitored and documented daily by Environmental Services throughout the facility. . Members of Nursing Administration will conduct and document random audits of resident care to ensure that resident privacy is maintained. Audits will be completed weekly throughout the facility for the next three (3) months. . Update policy titled, "Resident Rights Guidelines for All Nursing Procedures". All resident rooms have doors to the main entrance and current practice allows for main entrance door to remain open with the utilization of the privacy curtain to ensure resident privacy. . Nursing Administration will monitor staff training and education for completion through training sign-in sheets completion; monitor and ensure random audits are completed. Environmental Services will ensure privacy curtain is repaired and all resident rooms have proper barriers currently in place and of good repair. Documentation from Nursing Administration and Environmental Services will be provided to the QAPI committee for review. Frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 164	Continued From page 2 CNA revealed she was unaware the privacy curtain was not pulled until after the resident was unclothed and assisted to the toilet. 3. Observation on 1/27/15 at 10:25 AM showed resident #20 was assisted to the restroom in the common area by CNA #6. The resident was assisted with removal of his/her clothes and brief. During this observation the privacy curtain was broken and hanging off the hook, and did not cover the restroom opening which left the resident exposed to public view. Interview at that time with the CNA revealed she "didn't notice that side [of the curtain] was unsecured;" and the CNA was unaware of who was responsible for checking the privacy curtains to ensure good repair. 4. Review of the facility policy titled "Resident Rights Guidelines for All Nursing Procedures" dated October 2010 showed "...Close the room entrance door and provide for the resident's privacy..." 5. Interview on 1/28/15 at 6 PM with the DON verified the privacy curtain should be pulled to provide for resident privacy.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241	The care plan for Resident #13 was updated. 1:1 feeding for resident #13 has been discontinued as of 2/20/15. Staff provide "extensive assist" in accordance with his/her updated care plan. . The care plan for Resident #40 was updated. Meal assistance is being provided as per his/her care plan. . Resident #9 is no longer at the WRC facility. . Any residents requiring assistance could be affected by this practice.	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 241	Continued From page 3 Based on observation, staff interview, medical record review and policy review, the facility failed to ensure resident dignity was guaranteed for 2 sample residents (#9, #40) and 1 non-sample resident (#13) during dining. The findings were: 1. Review of the 12/13/14 quarterly MDS assessment showed resident #40 had diagnoses which included dementia and dysphasia, was severely cognitively impaired, needed assistance with eating, and had a history of coughing and choking with meals. Review of the care plan dated 12/23/14 showed staff were to be present to observe and assist the resident with meals. Continued observations on 1/28/15 from 4:30 PM to 5:10 PM revealed resident #40 sat in the wheelchair in the dining room with his/her food and liquids untouched. At 5:10 PM (40 minutes later), CNA #1 began to assist the resident. 2. Review of the 9/13/14 significant change MDS showed resident #13 had cognitive impairment due to dementia and required assistance with all ADLs. Review of the 12/9/14 care plan showed the resident required extensive assistance with eating. Review of the 1/14/15 physician's orders revealed an order for puree/liquefied diet and one-to-one assistance with eating. On 1/28/15 at 4:30 PM the resident was observed in the wheelchair at the dining room table. At 4:50 PM CNA #1 began to feed the resident sherbet and a liquid protein supplement. At 5:10 PM the CNA stopped assisting the resident and started feeding another resident. From 5:15 PM to 5:20 PM CNA #2 fed resident #13 (for 5 minutes), then started feeding another resident at another table. Resident #13 remained at the dining room table until 5:30 PM and during that time did not receive additional assistance.	F 241	Any resident who requires assistance will be brought to the dining area when there is an attendant ready to assist them. . The facility will continue to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. . Nursing and Dietary Manager, or designee, will ensure staff will be present to observe and assist the residents with meals as per physician orders and in accordance with the resident's care plan as evidenced by monitoring of meals for a duration of three (3) months. Frequency after 3 months will be determined by QAPI as compliance is demonstrated. . Dietary Manager, or designee, will ensure that the resident's requests at meals are fulfilled in accordance with physician orders and the resident's care plan in a timely and courteous manner as evidenced by monitoring of meals for a duration of three (3) months. Frequency after 3 months will be determined by QAPI as compliance is demonstrated. . Monitoring of meals will continue for every meal, on a daily basis, for five (5) days to ensure best practices are being followed. Documentation will be created for each meal being monitored. The frequency of monitoring meals will be reduced upon satisfactory performance as evidenced by supporting data. Continued monitoring will consist of three (3) .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 241	Continued From page 4 3. Review of the 12/13/14 significant change MDS showed resident #9 had severe cognitive impairment and required extensive assistance with eating. Review of the 12/23/14 care plan showed the resident required one-to-one assistance with meals. On 1/28/15 at 4:30 PM, the resident was observed in the dining room drinking hot chocolate. At 4:50 PM, s/he was served a cup of sherbet and ate 100% of the sherbet without assistance. At that time s/he told the surveyor s/he wanted more sherbet, but no staff was available to respond to the resident's request. From that time until 5:20 PM (30 minutes later) the resident sat waiting for additional food to be served. At 5:20 PM the resident was served ham, mashed potatoes and stewed tomatoes, and CNA #3 tried to encourage the resident to eat. The resident refused to eat and the CNA wheeled the resident to his/her room at 5:30 PM.	F 241	meals per month, to include one (1) breakfast meal, one (1) lunch meal, and one (1) supper meal. . Dietary Manager will monitor documentation from meal monitoring processes and provide information to QAPI committee for review. Reporting will be complete as determined by QAPI committee as compliance is demonstrated.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	Care plans for residents #13 and #23 were updated with current information on 2/19/15. . All residents could potentially be affected. . Interdisciplinary Team implemented a Kardex system for resident care plans to be kept on the inside closet door of the resident rooms. . Nursing staff will make changes to the Kardex as recommendations are received from physicians. Copies of these changes will be made and forwarded to the appropriate department for all residents. .	3/15/15

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
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 280	Continued From page 5 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff reviewed and revised the care plan to reflect each resident's status for 1 of 13 sample residents (#23) and 1 non-sample resident (#13). The findings were: 1. Review of the care plan for resident #13 revealed directions for staff to implement the following interventions to address problems with nutrition: a. Offer food in a variety of textures; b. Eat in the secure unit dining room because resident eats better with encouragement, extensive, assistance, and an atmosphere with less distractions; c. Try to replace missed breakfast, try putting foods with calories into his/her hands; d. Offer supplement when any meal is taken less than fifty percent; e. Currently on a mechanical soft diet; f. Talk with family about tube feeding placement. Interview on 1/27/15 at 9:20 AM with the MDS coordinator revealed a discussion with the family and physician about tube feeding placement had occurred in the past and was not a current intervention for the resident. Interview on 1/29/15 at 1:45 PM with the dietary manager revealed the	F 280	Each department head, or designee, is responsible for making changes to the care plan for their respective departments for all residents. Director of Nursing, or designee, will monitor orders and changes to the Kardex to ensure changes are made within 72 hours for all residents. Department heads will keep track of documentation of changes to the care plans and ensure updates are given to the MDS Coordinator for care plan completion for all residents. MDS Coordinator will monitor changes through documentation provided by department heads. MDS Coordinator will provide supporting documentation to QAPI committee for review. Reporting will be complete as determined by QAPI committee as compliance is demonstrated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 280	Continued From page 6 care plan interventions were not being used at this time. She also stated she was responsible for the nutrition section of the care plan and had not revised it according the resident's current needs. Observation of the resident during the evening meal on 1/29/15 revealed s/he was served a pureed diet in the main dining room and required total assistance with eating. 2. Review of the 11/22/14 significant change MDS assessment showed resident #23 had diagnoses that included dementia, was severely cognitively impaired, and needed extensive assistance with bed mobility and eating. Observation in the Women's secure unit dining room on 1/26/15 at 5:20 PM showed resident #23 needed total assistance to eat by staff and was served a puree dinner. Continued observation on 1/27/15 from 9:15 AM to 11:50 AM showed the resident made no significant position changes without staff assistance. The following concerns were noted: Review of the care plan showed the resident was to have a "pop tart snack at 10 AM...encourage finger type foods," "cut meat into bite-sized pieces...allow her to use her fingers to feed herself," and "encourage repositioning often." Interview with the MDS coordinator on 1/28/15 at 3 PM revealed the care plan should have been updated to reflect the resident's current need for repositioning by staff. Interview with the Dietary Manager on 1/29/15 at 12 PM revealed the care plan was not updated to reflect the current puree diet order changed on 1/21/15, 8 days earlier.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 282	Continued From page 7 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, and staff interview, the facility failed to ensure residents received showers/baths according to the care plan for 1 of 13 sample residents (#46). The findings were: Interview with resident #46 on 1/26/15 at 4 PM revealed s/he received showers/baths once a week or less. Review of the 7/18/14 significant change MDS assessment showed the resident required limited assistance from one staff member for showers/baths. Review of the resident's care plan concerning showers/baths, last updated 12/31/14 showed, "Bath/shower 1-2 * week (once or twice a week)..." The following concerns were identified: a. Review of the resident's December 2014 shower/bath record (Care Plan Flow Sheet Bath) showed the facility failed to ensure the resident received a shower/bath from 12/10/14 through 12/30/14 (20 days). Review of the resident's January 2014 shower/bath record showed the facility failed to ensure the resident received a shower/bath from 1/1/15 through 1/8/15 (8 days), and from 1/10/15 through 1/24/15 (14 days). Review of the entire medical record showed no additional documentation concerning showers/baths. b. Interview with employee #1 on 1/27/15 at 9:20 AM showed facility staff attempted to give showers/baths to residents twice a week, but due	F 282	Care plan for resident #46 was changed to reflect his/her preference for two (2) baths per week. Care plan update completed 2/18/15. . All residents could potentially be affected. The following has been implemented: . Care plans will be reviewed and updated to incorporate resident preferences. . Developed a bath schedule in accordance with resident preferences. Bath schedules are in place and were revised 2/20/15. . Bath CNA schedules will be adjusted, as necessary, to accommodate resident preferences. . Infection Control Nurse will monitor bathing procedures and CNA flow sheets for compliance with care plans and bath schedule for all residents. . Infection Control Nurse will monitor care plans to ensure updates have been made to bathing preferences; monitor documentation of bathing audits and provide this information to QAPI committee for review. Reporting will be complete as determined by QAPI committee as compliance is demonstrated.	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 282	Continued From page 8 to staffing issues the facility sometimes failed to ensure baths were always done as scheduled. c. Interview with the DON on 1/29/15 at 11 AM confirmed her expectation was for the facility to follow the care plan concerning showers/baths.	F 282		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure staff provided assistance with perineal care for 1 of 8 sample residents (#23); shower/baths for 1 of 13 sample residents (#46); and assistance with eating in a timely manner for 1 of 6 sample residents (#40) and 1 non-sample resident (#13) who required assistance with ADLs. The findings were: 1. Review of the 9/13/14 significant change MDS assessment showed resident #13 had cognitive impairment due to dementia and required assistance with all ADLs. Review of the 12/9/14 care plan showed the resident required extensive assistance with eating. Review of the 1/14/15 physician's orders revealed an order for puree/liquefied diet and one-to-one assistance with eating. On 1/28/15 at 4:30 PM the resident was observed in the wheelchair at the dining	F 312	1:1 feeding for resident #13 has been discontinued as of 2/20/15. Staff continue to provide feeding assistance in accordance with his/her care plan. Meal assistance is being provided to resident #40 as per his/her care plan. Care plan for resident #46 was changed on 2/18/15 to reflect his/her preference for two(2) baths per week. Assistance with personal hygiene for resident #23, and all residents, will be done according to the policy, "Perineal Care", and proper hand washing procedures will be followed in accordance with policy, "Handwashing/Hand Hygiene". All residents could potentially be affected. The following measures have been put into place: Nursing and Dietary Manager will ensure staff will be present to observe and assist the residents with meals as per physician orders and in accordance with the resident's care plan as evidenced by dietary monitoring of meals for a duration of three (3) months. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated.	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 312	Continued From page 9 room table. At 4:50 PM CNA #1 began to feed the resident sherbet and a liquid protein supplement. At 5:10 PM the CNA stopped feeding the resident and started feeding another resident. From 5:15 PM to 5:20 PM CNA #2 fed resident #13 (for 5 minutes), then started feeding another resident at another table. Resident #13 remained at the dining room table until 5:30 PM and during that time did not receive additional assistance. 2. Review of the 12/13/14 quarterly MDS assessment showed resident #40 had diagnoses that included dementia and dysphagia, was severely cognitively impaired, needed assistance with eating, and had a history of coughing and choking with meals. Review of the care plan dated 12/23/14 showed staff were to be present to observe and provide assistance during meals. The care plan documented, "Do not leave [the resident] sitting in the north common area or in [the resident's] room until last to be taken to the main dining room if there is no nursing staff person nearby to observe [the resident]. Take [the resident] to the dining room when you know there are other residents there-but not last. If no nurse can [sic] or nurse is in the main dining room, inform dietary staff [the resident] is there so they can be observant of [the resident]. Also: Eating: Meals in north dining room due to needing to be at a 90 degree position when eating ***use plate guard per family (limited assist)." Observation on 1/28/15 from 4:30 PM to 5:10 PM revealed resident #40 sat in the wheelchair in the dining room with his/her food and liquids untouched. At 5:10 PM, (40 minutes later) CNA #1 began to assist the resident. 3. Interview with resident #46 on 1/26/15 at 4 PM revealed s/he received showers/baths once a	F 312	Monitoring of meals will continue for every meal, on a daily basis, for five (5) days. The frequency of audits will be determined by the QAPI committee as compliance is demonstrated. Dietary care plans have been reviewed and updated to incorporate resident preferences as of 2/19/15. Developed a bath schedule in accordance with resident preferences. Bath schedules are in place and were revised 2/20/15. Bath CNA schedules will be adjusted, as necessary, to accommodate resident preferences. Infection Control Nurse will monitor and document bathing procedures weekly to ensure compliance with care plans and bath schedule for all residents. Staff were re-educated on handwashing/hand hygiene, perineal care, and linens at the February nursing in-service, 2/17/15 - 2/18/15. Competency checks will be completed at the nursing skills fair in March. Nursing Administration will perform and document random audits for handwashing/hand hygiene and perineal care throughout the facility. Infection Control Nurse will perform and document random audits for bathing procedures for all residents. Dietary Manager will perform and document random audits for meal assistance. Audits will be completed and documented weekly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 312	Continued From page 10 week or less. Review of the 7/18/14 significant change MDS assessment showed the resident required limited assistance from one staff member for showers/baths. The following concerns were identified: a. Interview on 1/26/15 at 4 PM revealed the resident was not satisfied with one shower/bath per week or less, and preferred 2 showers/baths per week. b. Review of the resident's care plan concerning showers/baths, last updated 12/31/14 showed, "Bath/shower 1-2 * week (once or twice a week)..." The facility failed to incorporate the resident's preference in the care plan. c. Review of the resident's December 2014 shower/bath record (Care Plan Flow Sheet Bath) showed the facility failed to ensure the resident received a shower/bath from 12/10/14 through 12/30/14 (20 days). Review of the resident's January 2014 shower/bath record showed the facility failed to ensure the resident received a shower/bath from 1/1/15 through 1/8/15 (8 days), and from 1/10/15 through 1/24/15 (14 days). Review of the entire medical record showed no additional documentation concerning showers/baths. d. Interview with employee #1 on 1/27/15 at 9:20 AM revealed facility staff attempted to give showers/baths to residents twice a week, but due to staffing issues the facility sometimes failed to ensure baths were always done as scheduled. e. Interview with the DON on 1/29/15 at 11 AM confirmed her expectation was for the facility to follow the care plan concerning showers/baths. 4. Review of the 11/22/14 significant change MDS assessment showed resident #23 had diagnoses that included dementia, and needed extensive assistance with personal hygiene. The following	F 312	Nursing Administration will monitor documentation from handwashing/hand hygiene and perineal care audits. Infection Control Nurse will monitor bathing procedure audits. Dietary Manager will monitor meal assistance audits. Nursing Administration, Infection Control Nurse, and Dietary Manager will provide documentation to the QAPI committee. The QAPI committee will review documentation. The frequency of future audits will be determined by the QAPI committee as compliance is demonstrated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 312	Continued From page 11 concerns were noted: Observation on 1/27/15 at 8:55 AM showed CNA #6 assisted the resident to the toilet. The CNA removed the resident's wet brief with ungloved hands, and did not perform hand hygiene before donning gloves and then removing the resident's remaining clothing. The CNA removed her gloves, and failed to perform hand hygiene before donning gloves again, and provided perineal care for the resident. The CNA wiped the resident's buttocks, then used the visibly soiled wipe two times more front to back. Interview at that time with the CNA revealed she usually folded over the wipe in this manner when performing perineal care. Interview with the DON on 1/28/15 at 6 PM revealed the facility expectation was to throw away a visibly soiled wipe and perform hand hygiene between glove changes. Review of the facility policy titled "Perineal Care" dated November 2010 showed "...Wash the perineum...using a clean area of the periwipe for each stroke. Do not reuse the same periwipe to clean the urethra..."	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced	F 318	Resident #46 was discharged 2/23/15 from Functional Maintenance Program (FMP) and will be re-screened for appropriate program, if applicable. . Documentation will be monitored weekly for resident #46, if new program is written. . All residents on Restorative Nursing Program/ Functional Maintenance Program (RNP/FMP) will be reviewed at monthly restorative meetings. Updates to care plans will be made as determined by restorative committee.	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 318	Continued From page 12 by: Based on medical record review and staff interview, the facility failed to ensure range of motion exercises were completed for 1 of 4 sample residents (#46) who required those interventions. The findings were: Medical record review showed resident #46 had diagnoses which included osteogenesis imperfecta (genetic disorder in which bones break easily), osteoarthritis, chronic pain, and degenerative disc disease. Review of the 12/26/14 quarterly MDS assessment for the resident showed s/he had bilateral range-of-motion impairment to the upper and lower extremities. Medical record review showed the resident had a 9/20/13 restorative care plan that included the following, "Passive range-of-motion to lower extremities 2-3 times per week as tolerated. May stop for periods of time and restart when he chooses". Review of the December 2014 and January 2015 restorative documentation showed the facility failed to document range-of-motion to the lower extremities for the resident from 12/15/14 through 12/22/14 (8 days), and from 12/31/14 through the survey on 1/28/15 (29 days). Interview with the DON on 1/29/15 at 11 AM confirmed her expectation was for staff to document the passive range-of-motion exercises or refusal 2-3 times per week as care planned, and confirmed the facility was uncertain if the range-of-motion exercises had been performed when not documented.	F 318	Nursing Administration will review documentation for residents who are receiving ordered restorative care. . Nursing Administration will provide supporting documentation to the QAPI committee for review. Future reporting will be completed as determined by the QAPI committee as compliance is demonstrated.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 323	Continued From page 13 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure effective interventions and/or post-fall assessments were implemented to prevent falls for 3 of 15 sample residents (#23, #46, #72) identified at risk for falls. The lack of assessments and effective interventions resulted in harm for residents #46 and #72. The findings were: 1. Review of the medical record for resident #72 showed s/he resided in the facility from 4/30/14 to 10/21/14. Review of the 10/14/14 care plan showed the resident had cognitive decline due to dementia and Alzheimer's Disease. Further review showed the resident was at risk for falls and interventions that addressed this problem included a motion sensor on the bed and alarms for the wheelchair and recliner. Review of the nursing notes and reports of incidents revealed the following concerns: a. On 8/13/14 the resident was trying to stand, lost his/her balance, stumbled backward and fell when the chair tipped over. Review of the post fall evaluation showed staff determined the intervention to prevent recurring falls was to increase staff observation. However, the facility failed to update the care plan to include increased staff observation as an intervention. b. On 9/6/14 a CNA found the resident on the	F 323	Residents #23 and #46 interventions have been reviewed and documented in care plans. . Specific interventions for Resident #23 consist of a high/low bed, mechanical lift for transfers, scoot mattress, and staff supervision. Resident is not mobile on his/her own and the care plan is updated as assessments necessitate. Each fall incident is documented and reported to nursing. Any immediate interventions needed are put into place by nursing. The IDT will investigate each fall incident and update care plan with appropriate interventions. IDT meetings occur every day Monday - Friday. . Specific interventions for Resident #46 consist of non-skid rug at bedside and front of recliner, Sara Lift, education on utilizing appropriate footwear, i.e. non-skid socks instead of slippers, use of single point cane or walker when in room and corridor, manual or electric wheelchair for locomotion on and off unit. Resident was re-educated on Falls prevention and interventions on 3/16/15. Education was documented in resident's chart. Resident is encouraged to ask for assistance. Nursing staff routinely observes resident. Fall risk assessment performed quarterly and care plan updated as assessment necessitates. Each fall incident is documented and reported to nursing. Any immediate interventions needed are put into place by nursing. The IDT will investigate each fall incident and update care plan with appropriate interventions. IDT meetings occur every day Monday - Friday. . Resident #72 is no longer a resident at the facility. .	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 323	Continued From page 14 floor in the resident's room with no injuries. Review of the medical record showed no evidence the fall was assessed as to potential cause or contributing factors. c. On 10/21/14 the resident was found in the bathroom "positioned face down with blood everywhere." ..."had skin tears" on the right elbow, "a laceration across the bridge" of nose, "another laceration beneath" the right eye, "a goose egg knot in the center" of the forehead with bruising, bruise on the upper lips and swelling, swollen nose, laceration on the inside of the upper lip, and bruises on the right hip. The ambulance transported the resident to the emergency department. Again, review of the medical record showed no evidence the fall was evaluated as to the cause and contributing factors. 2. Medical record review showed resident #46 had diagnoses which included osteogenesis imperfecta (genetic disorder in which bones break easily), osteoarthritis, chronic pain, and degenerative disc disease. Review of the 12/26/14 quarterly MDS assessment showed the resident was unsteady with moving from a seated to standing position, walking, turning around, moving on and off the toilet, and surface-to-surface transfers. Review of the Fall Risk Assessments for 2/12/14, 5/7/14, 7/14/14, 10/10/14, and 12/24/14 showed the resident was at risk for falls. Review showed the resident had a fall on 12/24/14 which resulted in a right tibia fracture. Review of a 12/24/14 incident report showed the resident was found on the floor of his/her room after the resident was heard yelling "help." The incident report showed the resident hit his/her head and right leg in the fall. Review of the incident report and the entire medical record	F 323	All residents could potentially be affected. The following steps have been taken to reduce the risk of falls: The fall incident and investigation forms were revised 2/19/15. Each incident will be reviewed and investigation completed by IDT team at next meeting. Meetings occur every day Monday - Friday. Each fall incident is documented and reported to nursing. Any immediate interventions needed are put into place by nursing. The IDT will investigate each fall incident and update care plan with appropriate interventions. IDT meetings occur every day Monday - Friday. The MDS Coordinator, or designee, will ensure interventions discussed at IDT meetings are communicated to staff, implemented, and care plans updated the day the interventions are discussed. Interventions will be communicated to staff through the use of a communications clipboard in each CNA locker room. The Falls QAPI-PIP Team will assess effectiveness of interventions at monthly meetings. The IDT will verify fall incident reports and fall investigation forms have been revised; monitor interventions discussed at IDT meetings and ensure care plans have been updated; monitor weekly fall intervention audits; monitor effectiveness of falls interventions as evidenced by documentation by Falls QAPI-PIP Team from monthly meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 323	Continued From page 15 showed no evidence the facility assessed the possible causes and contributing factors related to the fall. In addition, review of the care plan dated 12/31/14 titled "Activities of Daily Living (ADLs)/Risk for falls showed specific care interventions (physicans orders) but failed to address preventative measures. 3. Review of the 11/22/14 significant change MDS assessment showed resident #23 had diagnoses that included dementia and agitation, was severely cognitively impaired, and needed extensive assistance with bed mobility and eating, and total assist with transferring. Review of the care plan dated 12/4/14 showed the resident was at risk for falls. Review of the incident reports for the resident showed s/he had 29 falls from 1/6/14 to 12/18/14. Recommended interventions from the 1/6/14 fall included increased supervision of the resident by staff. In addition, the care plan was updated on 1/9/14 to include a soft helmet as an intervention. The following concerns were identified: a. After the care plan was updated to include increased staff monitoring on 1/6/14 and the use of a soft helmet on 1/9/14, the resident had an additional 21 falls all of which were unwitnessed. Medical record review showed no evidence a post-fall evaluation was performed after 17 of the 21 falls to identify potential causal factors to prevent reoccurring falls. b. Additionally, the investigation for the 4/8/14 fall intervention stated "I am at a loss for what to do for this res. [resident]." Further, the intervention for the 5/21/14 fall included "2nd staff member in unit during awake/active times of day." Additional review revealed interventions for the 5/27/14 fall included "ordered helmet and hip protectors last wk [week]" although the care plan	F 323	A fall risk assessment for all residents is performed quarterly and care plans updated as assessments necessitate. . The MDS Coordinator and IDT will provide documentation to the QAPI committee for review. Additional reporting will be completed as determined by the QAPI committee as compliance is demonstrated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 323	Continued From page 16 was updated 1/9/14 to include the soft helmet intervention already. 4. Interview with the DON on 1/29/15 at 11 AM verified performing post-fall assessments and determining effective interventions was an identified problem that had not yet been resolved. The DON said staff were not consistently performing post-fall evaluations to determine and implement care plan interventions individualized for each resident.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Discontinued Celexa for Resident #9 as of 2/19/15. . PMHNP (Psychiatric Mental Health Nurse Practitioner) assessed using observations of the residents, a chart review, and discussions with each resident and the staff who care for them, and a GDR or a risk versus benefit for continued use without attempts at tapering the dose of the medication was written for Resident #19 Zoloft is continued 3/11/15, Resident #23 Remeron was discontinued 3/10/15, Resident #25 Zoloft and Ativan are continued 3/10/15, Resident #39 Ropinorole was decreased 3/5/15 and Zoloft is continued 3/5/15, Resident #41 Depakote, Lamictal and Celexa are continued 3/11/15, and Resident #46 Seroquel is continued 3/13/15. . For all other residents who have orders for any psychoactive medications, PMHNP assessed using observations of the residents, a chart review, and discussions with each resident and the staff who care for them and a GDR or a risk versus benefit for continued use without attempts at tapering the dose of the medication was written for every resident who has orders for psychoactive	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 7 of 13 sample residents (#9, #19, #23, #25, #39, #41, #46). The findings were: 1. Review of the medication order form for resident #9 showed Celexa 20 mg daily (an antidepressant) was ordered on 8/9/10. Review of the 3/3/14, 5/13/14, 8/13/14, and 11/10/13 psychoactive drug review committee meeting records showed the committee determined the medication should be continued as ordered without change. Further review showed the physician did not document the risk versus benefits for continued use without attempts at tapering the dose of the medications. 2. Review of the medication order form for resident #19 showed Zoloft 125 mg by mouth every day (a medication for treatment of depression) was ordered on 3/19/13. Review of the 12/8/14 psychoactive drug review committee meeting records showed the committee determined the medication should be continued "indefinite[ly]" without change. Further review showed the physician did not document the risk versus benefits for continued use without attempts at tapering the dose of the medication. 3. Review of the medication order form for resident #23 showed Remeron 15 mg one-half tablet by mouth every evening at bedtime (a medication for treatment of depression) was ordered on 11/19/13. Review of the 11/8/14	F 329	medications and these were addressed by the attending physicians. . Residents on psychoactive medications are monitored for adverse drug reactions and the need for potential changes in these medications throughout the quarter and any changes needed are addressed immediately. During the quarterly psychoactive drug review meeting these changes will be reported and discussion with the consulting pharmacist concerning psychoactive medications will determine if it needs to be communicated to the physician the requirement of a GDR or a risk versus benefit statement of continued use without attempts at tapering the dose of the medication needs to be completed. . Medical records will monitor compliance through audits performed after every psychoactive drug meeting. Data will be provided to QAPI committee. . PMHNP will monitor compliance as evidenced by data provided by medical record's audits. . QAPI committee will review documentation provided by PMHNP. Additional reporting will be completed as determined by the QAPI committee as compliance is demonstrated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 329	Continued From page 18 psychoactive drug review committee meeting records showed the committee determined the medication should be continued "indefinite[ly]" without change. Further review showed the physician did not document the risk versus benefits for continued use without attempts at tapering the dose of the medication. 4. Review of the medication order form for resident #25 showed Zoloft 100 mg by mouth every day (a medication for treatment of depression) was ordered on 3/18/13. Additional review showed Ativan 0.5 mg by mouth 30 minutes prior to bathing (a medication for treatment of anxiety) was ordered on 8/20/13. Review of the 12/8/14 psychoactive drug review committee meeting records showed the committee determined the medication should be continued "indefinite[ly]" without change. Further review showed the physician did not document the risk versus benefits for continued use without attempts at tapering the dose of the medication. 5. Review of the medication order form for resident #39 showed Ropinirole .25 mg every morning and .5 mg every evening (medication for treatment of diseases of the nervous system) was ordered on 11/14/13. Further review of this medication order form showed Zoloft 100 mg daily (an antidepressant) was ordered on 9/20/13. Review of the 5/13/14, 8/13/14, and 11/10/13 psychoactive drug review committee meeting records showed the committee determined the medication should be continued as ordered without change. Further review showed the physician did not document the risk versus benefits for continued use without attempts at tapering the dose of the medications.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 329	Continued From page 19 6. Review of the medication order form for resident #41 showed depakote 500 mg by mouth every morning, 250 mg by mouth every day at lunch time, 750 mg every day at bedtime (medication for treatment of Bipolar disorder) was ordered on 7/27/11. Further review showed Lamictal 25 mg by mouth three times a day (a medication for treatment of agitation) was ordered on 9/18/12. Additional review showed Celexa 10 mg by mouth every day (a medication for treatment of depression) was ordered on 12/17/13. Review of the 1/12/15 psychoactive drug review committee meeting records showed the committee determined the medications should be continued "indefinite[ly]" without change. Further review showed the physician did not document the risk versus benefits for continued use without attempts at tapering the dose of the medication. 7. Medical record review revealed resident #46 had diagnoses which included bipolar disorder. Review of the January 2015 recapitulation of physician orders showed the resident had a 9/6/13 order for Seroquel (antipsychotic) 100 mg orally each morning and 300 mg each night. Review of the January 2015 MAR confirmed the resident received Seroquel. The following concerns were identified: a. Review of the monthly pharmacy drug regimen reviews for 2014 to current showed no indication a gradual dose reduction (GDR) or rationale as to why a GDR was not attempted was documented. b. Review of the 7/15/14, 9/9/14, and 12/8/14 quarterly Psychoactive Drug Reviews showed the physician signed the review each time. The documents revealed there was a physician response area to document a GDR regimen or	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 329	Continued From page 20 rationale for not attempting a GDR. However, the areas were left blank for all three reviews. c. Review of the entire medical record, which included physician progress notes, showed no GDR was attempted and no rationale was documented as to why a GDR was not attempted concerning the resident's Seroquel usage. 8. Interview on 1/28/15 at 10:30 AM with the nurse practitioner who was present during the Psychoactive Drug Review meetings confirmed the medications were continued indefinitely for all the residents on psychoactive medications when there were no adverse drug reactions present.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, policy and procedure and manufacture's instructions review, the facility failed to maintain a medication error rate under 5 percent (%). Three medication errors were observed out of 28 opportunities for error, which resulted in an error rate of 10.71%. The findings were: Observation on 1/28/15 at 4:30 PM showed RN #1 administered Symbicort inhaler two puffs to resident #37, but did not encourage the resident to rinse his/her mouth, and the nurse did not encourage the resident to wait one minute	F 332	Training of nursing staff occurred during the staff meeting on 2/17/15 & 2/18/15. Attendance was documented. . Resident #37 was educated by the Director of Nursing on 2/19/15 regarding inhaler use policy. . All residents using inhalers could be affected. . The following has been implemented: . A member of Nursing Administration attended the resident council meetings scheduled for March 3rd and 4th to educate residents on inhaler use. . Residents that use inhalers will be individually educated on proper use of inhalers. Education will be documented for each applicable resident. .	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 332	Continued From page 21 between puffs of the medication. The nurse then administered Combivent inhaler one puff, but did not encourage the resident to wait two minutes between inhaler medications. Interview at that time with the RN confirmed she should have encouraged residents to rinse after using the inhaler. Interview at that time with the DON verified the nurse should wait two minutes between inhalers and encourage the resident to rinse after. Review of the facility policy titled "Administering Medications through a Metered Dose Inhaler" dated October 2010 showed "...The following equipment and supplies will be necessary when performing this procedure...gargling solution...Allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications..." Review of the Symbicort manufacturer instructions showed "2. Dosage and Administration...After inhalation, the patient should rinse the mouth with water without swallowing..."	F 332	Random observations of medication passes will be completed and documented by Nursing Administration and/or Pharmacy two (2) times each month. Nursing Administration will monitor audits of medication passes and provide documentation to the QAPI committee. The QAPI committee will review audit documentation. Additional reporting will be completed as determined by the QAPI committee as compliance is demonstrated.	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure	F 365	Care plan for resident #19 was updated on 2/17/15 and meal assistance is being provided accordingly. Specific interventions include a regular diet, mechanical soft texture and eating on the North secure dining room to be set-up with supervision, resident prefers to feed self - does not like to be assisted. Any resident could potentially be affected all residents. The following has been put into place:	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 365	Continued From page 22 1 of 4 sample residents (#19) received the appropriate diet consistency. The findings were: Review of the 12/27/14 annual MDS assessment showed resident #19 had diagnoses that included dementia and needed supervision with eating. Review of the care plan dated 1/7/15 showed the resident had lost his/her upper denture. Review of the care plan conference dated 1/7/15 showed the power of attorney (POA) had requested a "soft diet as doesn't chew well anymore." The following concerns were noted: Observation in the Women's secure dining room on 1/27/15 at 12:20 PM showed the resident was served a regular diet for lunch. The resident ate a bite of his/her cheeseburger, chewed, spit out the food, repeated the process several times, and did not swallow any food. Additionally, the resident was not offered any help with the meal by staff, as the staff member was busy feeding another resident. Interview with the Dietary Manager (DM) on 1/27/15 at 5 PM revealed the POA had requested a mechanical soft diet trial for the resident at the care plan conference on 1/7/15, but the DM was unaware the order for a diet change had not been written. Interview at that time with the DON revealed she thought the DM had written the order for a mechanical soft diet trial of 3 days.	F 365	When a diet trial/change is initiated by a nursing intervention or physician order, nursing will ensure that the Dietary Manager, or designee, has a copy of the diet change through the use of the "Dietary Order & Communication" form. Nursing will update the Kardex located in the resident's room. It will be the responsibility of the Dietary Manager, or designee, to ensure the changed diet is reflected on the care plan and the resident receives the correct diet. When a diet trial/change is prompted during a resident care conference the MDS Coordinator, or designee, will assign a person present at the care conference to initiate the attainment of the needed order. Once order is received, process will continue as above. The process will be monitored at each care plan meeting for the next 90 days. Dining room seating will be rearranged to provide adequate meal assistance. QA committee will review care plan for resident #19 to ensure care plan is accurate and that care is being provided according to the plan; review documentation supporting residents are receiving appropriate diets and textures; and verify dining room seating has been rearranged. Documentation will be provided by Dietary Manager, or designee, supporting compliance. Additional reporting will be completed as determined by the QAPI committee and compliance is demonstrated.	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after	F 387	F387: Resident #46 was seen by the physician on 11/25/15 and documentation is on file. Resident #51 was seen by the physician on 10/13/15 & 12/31/15 and documentation is on file.	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 387	Continued From page 23 admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician visits were made every sixty days as required for 2 of 13 sample residents (#46, #51). The findings were: 1. Medical record review revealed the physician had seen resident #46 on 9/23/14. Review of the entire medical record showed no physician visits from 9/24/14 through the survey date of 1/28/15 (127 days). 2. Medical record review revealed the physician had seen resident #51 on 8/20/14. Review of the entire medical record showed no physician visits from 8/21/14 through the survey date of 1/28/15 (161 days). 3. Interview with the DON on 1/29/15 at 11 AM confirmed the physician dictated the visits and the facility frequently failed to ensure transcription of the physician visits was completed and placed on the resident's medical record in a timely manner.	F 387	All residents could potentially be affected. The following solutions have been implemented: Wyoming Retirement Center created a policy to ensure timely receipt of physician progress notes following physician rounds. The policy applies to all physicians, physician assistants, and nurse practitioners with privileges. . Practitioners with privileges at WRC are expected to complete progress notes from their rounds, initial history, physicals, and discharge summaries and provide a copy to WRC within ten (10) days of patient encounter. The Health Information Manager will monitor and ensure that the procedures of the policy are being followed. . Following practitioner rounds the rounding nurse will provide the Health Information Manager with a list of residents seen during rounds. The Health Information Manager will transcribe the progress notes of those practitioners who choose to use the provided Dictaphone. The Health Information Manager will document and keep record of receipt of all other progress notes. The Health Information Manager will provide the Medical Director, Nursing Home Administrator and Nurse Manager with a list of delinquent progress notes weekly with number of days delinquent noted. Medical records will contact physician office by email or phone to notify documentation is delinquent. If documentation is 10 days delinquent, Nursing Home Administrator will send a letter stating documentation is required within 5 days. . If documentation is not received within five (5) days from the patient encounter, the practitioner's privileges at WRC will be suspended.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 428	Continued From page 24 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimen was free from irregularities for 5 of 13 sample residents (#19, #23, #25, #41, #46). The findings were: 1. Review of the medication order form for resident #19 showed Ativan 0.5 mg by mouth every eight hours as needed (med for treatment of agitation) was ordered on 9/24/12. Additional review showed Zoloft 125 mg by mouth every day (a medication for treatment of depression) was ordered on 3/19/13. Review of the 12/8/14 psychoactive drug review committee meeting records showed the committee determined the medication should be continued "indefinite[ly]" without change. Further review showed the pharmacist failed to communicate with the physician the requirement for a gradual dose reduction (GDR) or a risk versus benefits statement for continued use without attempts at tapering the dose of the medication. 2. Review of the medication order form for resident #23 showed Remeron 15 mg one-half tablet by mouth every evening at bedtime (a medication for treatment of depression) was	F 428	Documentation regarding progress note compliance will be provided by the Health Information Manager to the QAPI committee for review. Additional reporting will be complete as determined by the QAPI committee as compliance is demonstrated. (END F387) F 428: The consulting pharmacist did a psychoactive drug review on 2/23/15 for Residents #19, #23, #25, #41, and #46 to communicate with the physicians the requirement of a GDR or a risk versus benefit statement for continued use without attempts at tapering the dose of medication needed to be written for #19 Zoloft and Ativan ordered, #23 Remeron ordered, #25 Zoloft and Ativan ordered, #41 Depakote, Lamictal and Celexa ordered, and #46 Seroquel ordered. Any residents who have orders for psychoactive medications were reviewed by the consulting pharmacist to communicate with the physicians the requirement for a GDR or a risk versus benefit statement for continued use without attempts at tapering the dose of the medication needed to be written. Consulting pharmacist will actively participate in psychoactive drug review meetings and will assist in the identification of medications that need a GDR or a risk versus benefit statement for continued use without attempts at tapering the dose of medication. Pharmacy recommendations regarding psychotropic use will originate from these meetings. These recommendations will be reviewed by the attending physicians on their	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 428	Continued From page 25 ordered on 11/19/13. Review of the 11/8/14 psychoactive drug review committee meeting records showed the committee determined the medication should be continued "indefinite[ly]" without change. Further review showed the pharmacist failed to communicate with the physician the requirement for a GDR or a risk versus benefits statement for continued use without attempts at tapering the dose of the medication. 3. Review of the medication order form for resident #25 showed Zoloft 100 mg by mouth every day (a medication for treatment of depression) was ordered on 3/18/13. Additional review showed Ativan 0.5 mg by mouth every 30 minutes prior to bathing (a medication for treatment of anxiety) was ordered on 8/20/13. Review of the 12/8/14 psychoactive drug review committee meeting records showed the committee determined the medications should be continued "indefinite[ly]" without change. Further review showed the pharmacist failed to communicate with the physician the requirement for a GDR or a risk versus benefits statement for continued use without attempts at tapering the dose of the medications. 4. Review of the medication order form for resident #41 showed depakote 500 mg by mouth every morning, 250 mg by mouth every day at lunch time, 750 mg every day at bedtime (medication for treatment of Bipolar disorder) was ordered on 7/27/11. Further review showed Lamictal 25 mg by mouth three times a day (a medication for treatment of agitation) was ordered on 9/18/12. Additional review showed Celexa 10 mg by mouth every day (a medication for treatment of depression) was ordered on	F 428	next rounds. The Director of Nursing attends the psychoactive drug review meetings and is part of the discussion and if not able to make the meeting is informed after the meeting of any recommendations. . Emissary Pharmacy Clinical Policy #5525- "Documentation and Communication of Consultant Pharmacist Recommendations" is in place to ensure that the reports are acted upon. . Medical records will monitor compliance through audits performed after every psychoactive drug meeting. Data will be provided to QAPI committee. . PMHNP will monitor compliance as evidenced by data provided by medical record's audits. . QAPI committee will review documentation provided by PMHNP. Additional reporting will be completed as determined by the QAPI committee as compliance is demonstrated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 428	Continued From page 26 12/17/13. Review of the 1/12/15 psychoactive drug review committee meeting records showed the committee determined the medications should be continued "indefinite[ly]" without change. Further review showed the pharmacist failed to communicate with the physician the requirement for a GDR or a risk versus benefits statement for continued use without attempts at tapering the dose of the medications. 6. Medical record review showed resident #46 had a 9/6/13 order for Seroquel (antipsychotic) 100 mg orally each morning and 300 mg each night. Review of the January 2015 MAR confirmed the resident received Seroquel. The following concerns were identified: a. Review of the monthly pharmacy drug regimen reviews for 2014 to current showed no indication that the pharmacist had identified a need for a GDR or rationale as to why a GDR would not be attempted for the resident's Seroquel as ordered. b. Review of the 7/15/14, 9/9/14, and 12/8/14 quarterly Psychoactive Drug Review showed the pharmacist attended those meetings. The documents revealed there was an area to document a GDR regimen or rationale for not attempting a GDR. However, the areas were left blank for all three reviews. c. Review of the entire medical record showed no GDR consideration concerning the resident's Seroquel usage. Interview with the pharmacist on 1/28/15 at 12:15 PM confirmed he failed to consider communicating with the resident's physician concerning the requirement for a GDR, or rationale why a GDR was not attempted for resident's when completing the monthly	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 US HWY 20 SOUTH BASIN, WY 82410

(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 428	Continued From page 27 medication regimen review.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	For Resident #8, Nursing staff were shown where paper towels are kept and Environmental Services checks off that paper towels are stocked everyday. For Resident #8, #23, and #25 all nursing staff were educated on policy and procedures regarding handwashing/hand hygiene and perineal care. Random audits are being performed by Nursing Administration to ensure policies and procedures are being followed. All residents could potentially be affected. The following interventions have been put into place: Provided mandatory education on nursing policy and procedures, handwashing/hand hygiene, and perineal care on 2/17/15 & 2/18/15. Nursing Administration will perform random audits for handwashing/hand hygiene, perineal care, use of bags and soiled linen procedures throughout the facility. Audits will be completed and documented weekly for two (2) months. Environmental Services will provide bags in all resident rooms to put soiled linen in. Yellow bags are provided in the soiled utility room for visibly soiled linens. Soiled linens will be placed in the appropriate bag. Gowns will be provided in soiled utility rooms. Housekeeping will document daily.	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 441	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy review, the facility failed to ensure appropriate infection control procedures were followed in a variety of areas which affected 3 resident's (#8, #23, #25). Additionally, the facility failed to ensure soiled linens were handled in an appropriate manner during 2 random observations. The findings were: 1. Observation on 1/27/15 at 8:55 AM showed CNA #6 and CNA #7 assisted resident #25 to the bathroom. The CNAs donned gloves, removed the resident's wet brief, removed their gloves, and did not perform hand hygiene before touching items in the bathroom. 2. Observation on 1/27/15 at 11:45 AM showed CNA #6 assisted resident #23 to the bathroom. With ungloved hands, the CNA removed the resident's wet brief, did not perform hand hygiene, donned gloves, and removed the resident's pants, removed her gloves, did not perform hand hygiene, donned new gloves and performed perineal care for the resident. The CNA wiped the resident's buttocks and then used the visibly soiled wipe two times more front to back. Interview at that time with the CNA revealed she usually folded over the wipe when performing perineal care. The CNA then removed the visibly soiled clothing from the resident's room with ungloved hands, did not bag the linens, and walked through the common area to the soiled utility room. Interview at that time with the CNA revealed she usually used hand sanitizer between	F 441	Environmental Services will ensure paper towels are stocked in appropriate areas. Housekeeping will document this daily for two (2) months. . Personal care will be provided per Handwashing/ Hand Hygiene and Perineal Care policies to all residents. . Nursing Administration will monitor audits, including handwashing/hand hygiene, perineal care, bag use and soiled linen procedures. Environmental Services will ensure that bags have been provided for each room and that paper towels are being stocked. . Nursing Administration and Environmental Services will provide supporting documentation to the QAPI committee for review. Reporting will be complete as determined by the QAPI committee as compliance is demonstrated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 441	Continued From page 29 glove changes. Additionally, she stated she did not usually bag linens that were soiled with food, only if the linens were "soiled with feces." 3. Observation on 1/27/15 at 9:55 AM revealed CNA #4 washed her hands, noted the paper towel dispenser was empty, dried her hands on her pants, put on a pair of gloves and assisted two other CNA's to reposition resident #8. Continued observation revealed the CNAs clothing including CNA #4's pants had repeated contact with the resident during repositioning. Interview with the DON on 1/28/15 at 6 PM revealed the facility expectation is to perform hand hygiene between glove changes, to throw away a visibly soiled wipe, and to bag soiled linens for transport to the soiled utility room. Review of the facility policy titled "Handwashing/Hand Hygiene" dated April 2012 showed "...use an alcohol-based hand rub...for all the following situations...after removing gloves..."	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520	All deficiencies identified in this State Survey will be reviewed by the QAPI committee. Departments have developed measurable goals and will provide supporting documentation to the QAPI committee on a quarterly basis, at a minimum. Data will be available to the QAPI committee, as requested, for review in between the scheduled quarterly meetings. The QAPI committee will address the concerns from the previous State Survey that were not remedied and were identified. The first meeting to verify department's compliance in meeting their goals is scheduled for March 12, 2015.	3/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 520	Continued From page 30 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on quality assurance program document review, review of the CMS-2567 (Centers for Medicare and Medicaid Services) and staff interview, the facility failed to ensure the quality assurance and performance improvement program (QAPI), known in the facility as the Quality Assurance Committee was effective in developing and implementing appropriate interventions to resolve identified issues, and establishing a program that enabled sustained compliance with previously identified issues. The findings were: Review of the facility's Quality Assurance Committee program showed the facility failed to resolve and/or maintain compliance with the following issues that were also cited during the previous survey of 12/5/13 on the CMS-2567: a. The facility failed to provide adequate toileting and shower/bath assistance. b. The facility failed to provide adequate assessments and interventions for fall safety. c. The facility failed to ensure proper infection	F 520	The QAPI committee will determine when reporting for each tag is complete based on satisfactory reviews of supporting documentation as compliance is demonstrated. WRC is transitioning to QAPI for quality assurance. If monitoring compliance is not demonstrated will create a QAPI-PIP to address areas of concern.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 520	Continued From page 31 control monitoring was in place to ensure adequate toileting assistance, adequate hand hygiene, adequate donning of gloves, and adequate handling of linens. Interview with the administrator on 1/29/15 at 1 PM confirmed the Quality Assurance Committee failed to resolve those issues.	F 520		