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

PRINTED: 02/16/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 1/30/17 through 2/2/17. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 226 SS=E	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also	F 226		

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

Lorna Dawson — RN DON — 3-2-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility investigation documentation, staff interview, and policy review, the facility failed to implement written policies related to reporting for 2 of 3 allegations of abuse or neglect (involving residents #20 and #30) reviewed. In addition, the facility failed to revise policies related to reporting to ensure compliance with federal regulations. The findings were: 1. Review of facility investigation documentation revealed the following: a. An allegation of verbal abuse by a staff member to resident #30 on 3/5/16 was not reported to Healthcare Licensing and Surveys (HLS) until 3/7/16. b. An allegation of neglect involving resident #20 which was dated 8/30/16 was not reported to HLS until 9/7/16. During an interview on 2/1/17 at 3:30 PM the administrator confirmed the dates of the notification to HLS for the two allegations. She stated she was out of the office when the written allegation involving resident #20 was received.	F 226	The facility will ensure written policies related to reporting abuse or neglect involving residents #20 and #30 will be accomplished as evidenced by: A) Any allegation of abuse should be reported immediately to the supervisor. The supervisor is to report the abuse allegation to the administrator, and/or DON. The alleged abuse will be reported to Healthcare Licensing and Surveys no later than two hours of the allocation of abuse. B) The abuse policy was updated 02/21/2017 stating any allegations of abuse will be reported to the supervisor immediately. The supervisor is to report the alleged abuse to the Administrator and/or DON. The administrator and/or DON is to report the alleged abuse no later than two hours of the alleged abuse. C)The SDC will hold an all staff in-service to instruct employees on 03/06/2017	03/06/17

3/3/17 - The POC accepted with agreed to change between Dawn Walker, Admin and Tony Madden, Health Surveyor.

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F 226	Continued From page 2 She stated the staff person who handled the allegation involving resident #30 no longer worked in the facility, so she was unsure why it was reported late. 2. Review of the facility's policy "Procedure to handle suspected abuse, neglect and misappropriation of funds" (reviewed 12/2016) showed "Allegations are to be reported immediately (within 24 hours) to the following agencies and actions taken to prevent recurrence: The Department of Healthcare Licensing and Survey..." 3. During an interview on 2/1/17 at 3:30 PM the administrator stated she was unaware of new federal regulations for nursing homes effective November 28, 2016. Specifically, she was not aware that allegations of abuse and other allegations involving harm were to be reported within 2 hours. She stated the facility's policies had not been updated.	F 226	of the changes made to the abuse policy as set fourth by the interpretive guidelines. D) The administrator & DON have reviewed all CMS nursing home regulation updates and signed up for mailing list to receive updates to regulations in a timely manner. E)DON will report as function of QAPI	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 3 of 4 resident areas (100 hall, 200 hall, 300 hall) were in good repair. The findings were: 1. Observation of the 100 hall on 2/1/17 showed the following: a. Observation on 2/1/17 at 5:30 PM revealed	F 253	483.10(i)(2) Housekeeping and Maintenance Services (i)(2) Housekeeping and maintenance services are to maintain a sanitary, orderly, and comfortable interior. 1a) Regarding worn area on emergency doors. Doors will be repainted as planned. Painting has been scheduled for March 2017.	03/30/17

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F 253	Continued From page 3 the emergency doors had a worn area 26 ½ inches up from the floor that measured 3 feet by 2 inches and exposed the underlying metal which created surface that could not be cleaned effectively. b. Observation of the shower room at 5:35 PM showed the lower 3 inches of the doorway protector was broken off and left a rough sharp surface. The corner wall by the sink had an area where the plaster was broken away and exposed the underlying metal above the wall trim. The wall opposite of the sink had 2 damaged areas 9 inches up from the floor. The first was 30 inches from the wall and measured 4 inches, and the second was 43 inches from the wall, and measured 14 inches where the underlying material was exposed. Further, the wall had 3 areas 9 inches up from the floor that were 58 inches from the wall, 60 inches from the wall, and 62 inches from the wall where the surface had been damaged and the underlying drywall tape was exposed. The damaged areas created a surface that could not be cleaned effectively. c. Observation at 5:45 PM in room #102 showed open holes around the door edge on the top and left side of the metal trim that were rough to the touch and could not be cleaned effectively. 2. Observation of the 200 hall on 2/1/17 showed the following: a. Observation of the main entrance at 5:48 PM showed there was chipped paint measuring 2 1/2 inches by ½ inch near the wander guard box that could not be cleaned effectively. b. Observation of the hall in front of room #203 at 5:57 PM showed the carpet had 3 black spots that measured ½ inch by ½ inch, 3 inches by ½ inch, and 1 inch by ¼ inch. c. Observation of the hall carpet between	F 253	1a) Regarding worn area on emergency doors. Doors will be repainted as planned. Painting has been scheduled for March 2017. 1a) doorway protector was repaired 02/24/2017 to ensure no injury to residents. 1b) Regarding the West Hall shower room walls: West Hall shower room will be shut down for new construction scheduled 03/30/2017. We will be using the newly remodeled bathroom on NorthHall no later than 03/30/2017. 1c) Regarding open holes around doors edge in room #102. All damaged door trim will be repaired by 03/30/2017 2a)The chipped paint in the main entrance will be refinished and repainted by 03/30/2017 2,c) In regards to carpet in front of room #203, #205, and #207; all of East Hall carpet will be deep cleaned in an attempt to remove the stains.	

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F 253	Continued From page 4 room #205 and #207 at 6 PM showed 3 gray stains that measured 4 inches by 4 inches each. 3. Observation of the 300 hall on 2/1/17 showed the following: a. Observation of the housekeeping door at 5:50 PM showed chips in the paint that exposed the underlying surface and could not be cleaned effectively. 4. Interview with the maintenance director on 2/2/17 at 9:30 AM verified the identified areas were in need of repair.	F 253	3a) In regards to the housekeeping door on North Hallway is to be re-sanded and painted. Maintenance staff were educated on 02/23/17. To prevent future recurrence, maintenance emergency doors, carpet, and door trim monthly and report as a function of QAPI.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the Resident Assessment Instrument User's Manual, the facility failed to ensure quarterly MDS assessments were completed no less than every 3 months for 1 of 9 sample residents (#21) with quarterly MDS assessments. The findings were: 1. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, October 2016," by the Centers for Medicare and Medicaid Services, showed a quarterly assessment should have an assessment reference date (ARD) of no later than 92 days from the ARD of the previous	F 276	The facility will ensure quarterly MDS assessments will be completed as indicated in the Resident Assessment Instrument User's Manual. Assessment should be completed every 92 days. A) The MDS Coordinator will complete quarterly assessment as for resident #21 every 92 days. B) The DON will complete a monthly review of resident #21 assessments to ensure proper and timely completion of quarterly assessments. C) The DON will ensure MDS Coordinator is knowledgeable of the timing of ~~the~~ quarterly assessments	02/28/17

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F 276	Continued From page 5 federally mandated assessment. 2. Review of the admission MDS assessment for resident #21 showed an ARD of 7/4/16. Review of the subsequent quarterly MDS assessment revealed an ARD of 10/28/16 (116 days after the ARD of the admission assessment). During an interview on 2/2/17 at 9:15 AM the DON confirmed the quarterly MDS assessment was completed more than 92 days after the admission assessment.	F 276	D) DON will report as a function at QAPI.	
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on review of the facility's elimination protocol, staff interview, and medical record review, the facility failed to ensure interventions were implemented for lack of bowel movements (BMs) in accordance with the elimination protocol for 6 of 10 sample residents (#3, #21, #25, #27, #30, #35) reviewed. The findings were: Review of the facility's "Elimination Protocol" showed "...3rd Day (72 hours without a BM) 2 Senokot [laxative] tabs along with walking and fluids. Document senna on MAR comment sheet. 4th Day-Day Shift: Colace [stool softener] with walking and fluids. Assess bowel sounds. Document Colace on MAR comment sheet and follow up on BM (yes/no). Document in chart. EVE [evening] shift: MOM [Milk of Magnesia - a laxative] with walking and fluids. Assess bowel sounds. Document MOM on MAR comment sheet and follow up on BM (yes/no). Document in chart. NOC [night] Shift: Bisocodyl suppository. Assess bowel sounds. Document suppository on MAR comment sheet and follow up on BM (yes/no). Document in chart. 5th Day- Assess bowel sounds- Fleets Enema- Notify physician and document in chart." The following concerns were identified regarding failure to follow the protocol: 1. Review of the BM record and MARs for resident #3 revealed the following: a. According to the January 2017 BM record, the resident did not have a BM from 1/12 through 1/16 (5 days), 1/18 through 1/22 (5 days), and 1/24 through 1/30 (7 days). Review of the MAR and nursing notes showed no PRN (as needed) interventions in accordance with the elimination	F 309	The facility will ensure bowel protocol will be followed as evidenced by A) The bowel protocol will be placed on the MAR/Treatment sheets. The new process will start March 1, 2017. B)The NOC charge nurse will compile a list of residents who have had no bowel movement starting at day 3 and above and give to the oncoming charge nurse. C) The charge nurse will initial the appropriate date on the bowel protocol in the MAR/Treatment sheet. The charge nurse is to document on MAR comment sheet what medication was given. If the resident has gone 4-5 days without a bowel movement, the charge nurse is assess bowel sounds and for abdominal distention and give medication per bowel protocol. The charge nurse is to document bowel assessment in the resident's chart. The bowel sheets are to be turned into the DON daily.	~~03/01/17~~ 3/6/17 am

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F 309	Continued From page 7 protocol were administered. b. Review of the December 2016 BM record showed the resident did not have a BM 11/28 through 12/3 (6 days), and 12/15 through 12/19 (5 days). According to the MAR and nursing notes, there were no interventions for constipation documented on those dates. 2. Review of the January 2017 BM record showed resident #21 did not have a BM documented from 1/18 through 1/21 (4 days), or on 1/25 through 1/28 (4 days). Review of the MAR and nursing notes showed no interventions were documented during those time frames in accordance with the elimination protocol. 3. Review of the January 2017 BM record revealed resident #35 did not have a BM documented from 1/13 through 1/16 (4 days), 1/19 through 1/22 (4 days), and 1/24 through 1/27 (4 days). Review of the MAR and nursing notes failed to show any interventions related to the elimination protocol. 4. Review of the January 2017 BM record showed resident #27 did not have a BM documented 1/26 through 1/29 (4 days). Review of the MAR and nursing notes showed no interventions related to the elimination protocol were documented. 5. Review of the January 2017 BM record showed resident #30 did not have a BM documented 1/3 through 1/7 (5 days), 1/9 through 1/13 (5 days), 1/16 through 1/19 (4 days). Review of the MAR and nursing notes showed no interventions for constipation were administered during those timeframes. 6. Review of the December 2016 and January	F 309	D) The DON will review residents #3/ #21,#35, #27, #30, and #25 monthly to ensure bowel protocol interventions have been documented. E) Nurses will be educated on new procedure on 03/06/2017. F) NOC nurses will audit MAR's and TAR's monthly G) DON will report as a function of QAPI.	

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F 309	Continued From page 8 2017 BM records showed resident #25 did not have a BM documented 12/13 through 12/21 (9 days), or 1/8 through 1/12 (5 days). According to the MAR and nursing notes showed no interventions were documented during those time frames in accordance to the elimination protocol. 7. During an interview on 2/2/17 at 9:15 AM the DON stated nursing staff should follow the elimination protocol and document interventions on the MAR. She stated she had copies of the "elimination protocol" sheets that nurses used to track days without a BM and interventions given, which she kept in her office. The facility provided copies of the documentation for the above mentioned residents, but the documentation failed to show any constipation interventions for the applicable dates.	F 309		
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure expired medications were not available for use in 2 of 2 medication carts	F 425	The facility will ensure 2 of 2 medication carts will be checked monthly for expired medications as evidenced by: A) The NOC charge nurse will check each medication cart and med room monthly for expired medications. The NOC charge nurse is to pull any expired medications from the MAR and Med. room and place them in a box. The NOC charge nurse is sign off the MAR check sheet in the front of the MAR book.	03/06/17 and med room

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F 425	Continued From page 9 and 1 medication room. The findings were: 1. Observation of the East/West medication cart on 2/1/17 at 2:30 PM showed benzonatate 200 mg capsules expired 8/24/16, ondansetron HCl 4 mg tablets expired 8/24/16, and ondansetron HCl 4 mg expired 11/5/16. 2. Observation of the North medication chart showed 3 bottles of carbamide peroxide 6.5% (Ear drop wax removal) two of which expired 7/16, and one which expired 12/16. 3. Observation of the Medication room showed 1 milliliter bottle of 0.9% sodium chloride irrigation solution expired 7/1/16. 4. Interview with RN #1 on 2/1/17 at 4:00 PM verified the medications were available for resident use and were past the expiration date.	F 425	B) The expired medications are to be given to the DON and a medication destruction log will be filled out and the expired medications will be disposed of as per guidelines. C) The DON will instruct the Nursing staff on 03/06/2017 in a nursing staff meeting. D) DON will audit quarterly and report as a function of QAPI.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		

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F 514	Continued From page 10 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of elimination protocol documentation, the facility failed to ensure the medical record was accurate and complete for 2 of 10 sample residents (#3, #35). The findings were: 1. During an interview on 2/2/17 at 9:15 AM the DON stated nursing staff should document interventions administered in accordance with the elimination protocol on the MAR. However, during an interview on 2/2/17 at 9:42 AM the medical records/CNA manager and DON stated nursing staff also documented on the "elimination protocol" sheets, which the DON kept in her office. She stated that information was not part of the medical record. 2. Review of the "elimination protocol" sheets and medical record for resident #3 for January 2017	F 514		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(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 514	Continued From page 11 revealed the following: a. The resident was given lactulose [stool softener], Colace [stool softener], and MOM [Milk of Magnesia - a laxative] on 1/5/17. Review of the MAR and nursing notes showed no documentation related to this. b. The resident was given Colace, senna [laxative], and MOM on "1/9/17-1/10/17." Review of the MAR and nursing notes showed no documentation related to this. 3. Review of the "elimination protocol" sheets for January 2017 showed resident #35 was administered senna on "1/10-1/11." Review of the MAR and nursing notes showed no documentation related to this.	F 514	The facility will ensure as with resident #3 and #35, documentation of bowel protocol interventions are documented in the resident's chart and the MAR comment sheet as evidenced by The Charge Nurse notified the resident's #3 and #35 physicians of the problem. A)The Charge Nurse is to turn the daily bowel list in the DON daily. The DON will audit the resident's chart and the MAR/Treatment sheet weekly for documentation. B) The DON will instruct the Nurses at the nurse's meeting on 03/06/2017. C) DON will report on MAR/TAR's as related to BM protocol as a function of QAPI.	03/01/17

3/3/17