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

5/12/17

PRINTED: 04/20/2017
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
	536019	A. BUILDING _____ B. WING _____	C 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	398 SOUTH US HWY 20 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 4/3/17 through 4/6/17. Complaints reviewed in the course of this survey were complaint intakes WY000002365, WY000002377, and WY000002378. 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 RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 164 SS=D	483.10(h)(1)(3)(l); 483.70(l)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) 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. (h)(3)The resident has a right to secure and confidential personal and medical records. (l) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(l)(2) or other applicable federal or state laws.	F 164	F164 This requirement will be met as evidenced by: 1. Nursing staff will be in-serviced at next scheduled nursing meeting onMay18, 2017 on need to ensure that the electronic medical records are secure and only those with a need to know will have access to the medical electronic medical records.	6/4/17

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

Donne Bargeron RN, CNO — 5/11/17

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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MAY 11 2017
Healthcare Licensing and Surveys

Accepted with changes on page 13.
These changes were made per conversation with Donne Bargeron, DON. DOC - 6/4/17 Kodee Mers 5/12/17

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F 164	Continued From page 1 §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to ensure medical records were secure during 2 random observations of the report room. The following concern was identified: 1. Observation of the report room on 04/05/17 from 1:35 PM to 1:51 PM (16 minutes) showed the electronic medical record for a facility resident was open on the computer and no staff were present. The room was located near the common area where residents and family were seated.	F 164	2. Nursing staff will be educated on 5/18/2017 that the electronic record does closedown after 15 minutes but staff is still responsible for logging out of the electronic medical record when moving away from the computer. 3. The computer in the report room was moved on April 24, 2017 so that screen is not facing the doorway at any time to ensure privacy of electronic medical records when displayed on the computer screen. QA: Random checks will be completed each month by the Director of Nursing or designee to ensure privacy for all electronic medical records. A report will be provided quarterly at the Quality Assurance Performance Improvement meeting.	6/4/17

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F 164	Continued From page 2 The door to the room was open and the computer screen was facing the open door to the common area. The computer system identified CNA #1 as the user that was logged into the system. 2. Observation of the report room on 04/06/17 at 3:23 PM showed the medical record of a facility resident was open on the computer and no staff were present. The door to the room was open. The computer system identified CNA #1 as the user that was logged into the system. 3. Interview with the DON on 4/6/17 at 9:30 AM revealed staff are to log out of the computer charting system when they are not using it to ensure privacy of residents' personal information. 4. Review of "Resident Rights" received from the facility on 4/6/17 at 10:30 AM showed "The facility shall protect and promote the rights as identified below. Each Resident, and his/her legal representative as appropriate, has the right:...14. To have clinical and personal records kept confidential..."	F 164		
F 166 SS=E	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances	F 166	F 166 This regulation will be met as evidenced by: A. The facility will ensure that all grievances will be investigated and efforts made by the facility to resolve including those listed by residents #17, #20, #21, and #12.	6/4/17

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F 166	Continued From page 3 regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being	F 166	1. Nursing staff will be educated on 5/18/2017: a. Any concerns expressed by residents will be submitted to the Director of Social Services via the STAT messaging system on the electronic medical records immediately. b. How to use the STAT messaging system on the electronic medical record. c. Social Services will complete a grievance form on all grievances and determine how to proceed. d. Social Services will create a log for all grievances with resolutions. e. Suspected abuse will be investigated by Social Services upon notification. Quality Assurance: Social Services or designee will have all grievances filled out on a grievance form and logged on the grievance log. This log will be	6/4/17

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F 166	Continued From page 4 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interview, and policy and procedure review, the facility failed to ensure grievances were resolved for 4 of 4	F 166	monitored and reported on quarterly at Quality Assurance Performance Improvement meeting.	4 6/14/17

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F 166	Continued From page 5 sample residents (#12, #17, #20, #21) who voiced grievances. The findings were: 1. Interview with the resident #17's family member on 4/5/17 at 9:40 AM revealed a concern had been reported to the DON about CNA #2. The family member stated the CNA is "rude and rough" with the resident and "forces" the resident to use his/her injured arm to transfer which causes the resident "significant pain." The family member felt that if the CNA gets in trouble for not caring for the resident then the resident would be retaliated against by the CNA not answering his/her call light or not providing assistance. The family stated, "nothing gets done" about the concerns, however, the family member was concerned about reporting it again out of fear the facility would discharge the resident. 2. Interview with the resident #17 on 4/5/17 at 1:50 PM revealed s/he had previously reported concerns about rough treatment by CNA #2 to the nurse and was told the nurse would "talk" to the CNA about it. The behavior did not improve and the resident revealed s/he was "afraid" to bring it up again. The resident felt the CNA was impatient and tells him/her to "get up" without providing assistance and the CNA gets louder when she is upset with the resident. Further, the resident stated s/he felt "uncomfortable," "like a burden," "embarrassed," and "intimidated" by the CNA. There was no evidence a grievance form was completed related to the resident's concerns. 3. Interview with resident #21 on 4/4/17 at 9 AM revealed the resident had reported, to the nurses and DON, that CNA #2 is "rude." Further, the resident said s/he reported concerns about staff and was told s/he "can go someplace else."	F 166		6/4/17

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F 166	Continued From page 8 There was no evidence a grievance form was completed related to the resident's concerns. 4. Review of a nurse's note dated 1/11/17 and timed 12:42 AM showed resident #21 reported s/he did not like the CNA "that was in here." The nurse talked to the resident "1 to 1" at that time. There was no evidence a grievance form was completed related to the resident's concerns. 5. Review of a nurse's note dated 1/13/17 and timed 11:30 AM showed resident #21 complained of care that was provided. The nurse told the resident s/he needed to express his/her concerns to the DON and "if [s/he] is not happy in this facility [s/he] could always consider another facility." There was no evidence a grievance form was completed related to the resident's concerns. 6. Review of a nursing note dated 1/15/17 and timed 1:50 PM showed resident #21 reported that "aides" were not taking him/her to the bathroom during the shift and the previous night. Further, the note showed the CNAs stated the resident was visiting with family and was taken to the bathroom after the visit. There was no evidence a grievance form was completed related to the resident's concerns. 7. Interview with resident #12 on 4/4/17 at 3:30 PM revealed the resident had reported to facility staff s/he wanted a new wheelchair, and also that s/he was missing an afghan blanket. 8. Interview with resident #20 on 4/5/17 at 1:30 PM revealed s/he was missing "23 tops," and s/he had reported the missing items to "several" CNAs.	F 166		6/4/17

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F 166	Continued From page 7 9. Review of the grievance log showed there had been no identified grievances since June 2016. There was no evidence a grievance form was completed related to the residents' concerns. 10. Interview with the social services director on 4/6/17 at 8:15 AM revealed the facility had not received any formal grievances since 6/9/16 and had identified the grievance system as an area for improvement in January 2017; however, she was not aware of the grievances for resident #17, #20, or #21. Further, she revealed the facility has tried different wheelchairs for resident #12 and the resident had concerns with all of them; however, she was not aware the resident was missing an afghan blanket or that the resident was unhappy with the current wheelchair. 11. Review of the policy titled "Resident Grievance Policy" last revised on 4/25/16 showed "...3. Resident Grievances will be tracked by the Quality Improvement Committee A. Social Services will be responsible for tracking and reporting Resident Grievances quarterly, or more often as required, to the Quality Improvement Committee. B. Social Services will be responsible to make the administrator aware of on-going concerns...Process...1. Notify the Social Services Person for assistance in resolving the problem. The Social Service Person serves as the facility's in-house "ombudsman." An "ombudsman" investigates complaints on behalf of the administrator and reports findings/resolution to the Administrator. This report may either be done verbally or written. The Social Service Person will be happy to write concern for the resident. 2. If you are not satisfied notify the Director of Nursing. 3. Should you remain unsatisfied, please take the concern to the Administrator. You are	F 166		6/4/17

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F 166	Continued From page 8 welcome to present the problem verbally or in writing. You may expect a response at each level as quickly as possible, certainly within 5 working days..." 12. Review of "Resident Rights" received from the facility on 4/6/17 at 10:30 AM showed "The facility shall protect and promote the rights as identified below. Each Resident, and his/her legal representative as appropriate, has the right:...11. To voice grievances and suggest changes in policies and services to either staff or outside representatives without fear of restraint, interference, coercion, discrimination or reprisal. The facility shall listen to and act promptly upon grievances and recommendations received from Residents and family groups..."	F 166		
F 167 SS=B	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with	F 167	F167 This requirement will be met as evidenced by: 1. The Director of Social Services will review with residents at the next scheduled resident council meeting May 4, 2017 the location of the most current survey results and will be clearly visible at all times. 2. A note will be made available in the current survey notebook stating that theprevious3 years of surveys are available upon	6/4/17

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F 167	Continued From page 9 respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to ensure survey results and a notice of the availability of previous surveys were posted in an area readily accessible to residents. The census was 25. The findings were: 1. Observation on 4/4/17 at 9:26 AM showed a binder containing the most recent survey results was in a file wall pocket, behind the piano in the main lobby, not easily viewable or accessible to all residents. Further observation showed there was no posted notice that surveys from the preceding 3 years were available for review upon request. 2. Group interview on 4/4/17 at 1 PM with 11 residents present revealed that they did not know where the survey results were located. 3. Interview on 4/5/17 at 5:54 PM with the social services director confirmed that the survey results binder was behind the piano and not easily accessible to all residents, and that only the last survey is in the binder. She further revealed she had the prior year's surveys "somewhere."	F 167	request from the Director of Social Services. Quality Assurance: 1. Director of Social Services or designee will do random checks monthly to ensure the current survey is clearly visible and will report on such at the Quality Assurance Performance Improvement meeting quarterly. 2. The Director of Social Services will review location of survey results every month at the scheduled resident council meeting and report quarterly at the Quality Assurance Performance Improvement meeting on a quarterly basis.	6/4/17
F 221	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE	F 221	F221: This regulation will be met as evidenced by:	

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F 221 SS=D	Continued From page 10 FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure 1 of 25 sample residents (#24) was free from unnecessary	F 221	1. Resident#24 and all other residents will be free of physical restraints. 2. Resident #24 and all other residents who use recliners daily and/or prn will be assessed for safety and ability to use recliner. 3. Nursing staff will review the Restraint Policy at nursing meeting on 5/18/2017 with education on what or what is not considered a physical restraint. QA: Director of Nursing or designee will perform random checks of commons area as well as patient rooms monthly to ensure no unauthorized restraints are in use. To be reported quarterly at Quality Assurance, Performance Improvement meeting.	6/4/17

DR 5/12/17

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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
	535019	A. BUILDING _____ B. WING _____	C 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 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 221	Continued From page 11 physical restraints. The findings were: 1. Observation on 4/6/17 at 8:50 AM showed resident #24 was sitting in a recliner in the main lobby area with his feet elevated on the foot rest. A trash can was placed under the foot rest. The following concerns were identified: a. Review of the resident's history and physical dated 11/7/16 showed the resident had a left upper extremity amputation. b. Review of the resident's care plan showed that s/he had a care plan for ADLs with a goal to achieve maximum functional mobility. The fall/safety approaches included mobility alarm. There was no evidence a restraint assessment was performed related to the placement of the trash can under the recliner foot rest. 2. Interview on 4/6/17 at 8:54 AM with CNA #3 revealed the trash can was put under resident's recliner foot rest to prevent him/her from lowering his/her legs. 3. Interview with the DON on 4/6/17 at 9:20 AM revealed there was not a safety evaluation for placement of the trash can under the recliner while the resident's legs were elevated. Further, she revealed staff were not to place the trash can under the recliner because it prevented the resident from moving. 4. Review of facility policy and procedure on restraints with an issue date of 8/13/14 showed the purpose as, "...to identify the need for a physical restraint and to ensure the safety of the resident...The DON or designee will complete the physical restraint consent form to determine if appropriate and safe."	F 221		6/4/17

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F 225 F 225 SS=E	Continued From page 12 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that	F 225 F 225	F225 This regulation will be met as evidenced by: 1. Investigations were conducted for concerns expressed by residents #17 and #21 with inability to substantiate abuse allegations. 2. Any concerns voiced by residents to staff will be communicated to Social Services via the STAT messaging on the electronic medical record. 3. Social Services will keep a log of all grievances and resolutions. 4. Human Resources will complete background checks on CNA #2, CAN #4, and RN#1 with completed record placed in the appropriate personnel file. Quality Assurance:	6/4/17

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F 226	Continued From page 13 cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interview, medical record review, and policy and procedure review, the facility failed to ensure abuse allegations were investigated for 2 of 3 abuse allegations which involved 2 sample residents (#17, #21). Further the facility failed to ensure pre-hire screening was performed for 3 of 9 employees (CNA #2, CNA #4, RN #1) prior to resident contact. The findings were: 1. Review of the 3/27/17 significant change MDS assessment showed resident #17 had a BIMS	F 225	1. Social Services or designee will complete a monthly report on grievances and resolutions to ensure cully completed with a report to Quality Assurance Performance Improvement on a quarterly basis. 2. Social Services or designee will monitor new employee logs completed to ensure all appropriate background check and/or abuse registry checks are completed monthly and report to Quality Assurance Performance Improvement on a quarterly basis.	6/4/17

5/12/17

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F 225	Continued From page 14 (brief interview for mental status) score of 15 (cognitively intact), was able to understand and be understood and required extensive assistance of 2 or more people for bed mobility, transfers, dressing, and toilet use. The following concerns were identified: a. Interview with the resident's family member on 4/5/17 at 9:40 AM revealed the resident was afraid of CNA #2. The family member stated the CNA is "rude and rough" with the resident and "forces" the resident to use his/her injured arm to transfer which causes the resident "significant pain." The family member stated the concern was taken to the DON; however, "nothing gets done." The family member felt that if the CNA got in trouble for not caring for the resident then the resident would be retaliated against by the CNA not answering his/her call light or not providing assistance. Further, the family member was concerned about reporting the concern again out of "fear" the facility would discharge the resident. b. Interview with the resident on 4/5/17 at 1:50 PM revealed CNA #2 was physically rough with him/her during cares and it caused the resident pain. The resident felt the CNA was impatient and told him/her to "get up" without providing assistance and the CNA got louder when she was upset with the resident. Further, the resident stated s/he felt "uncomfortable," "like a burden," "embarrassed," and "intimidated" by the CNA. The resident revealed s/he had previously reported the CNA behaviors to the nurse and was told the nurse would "talk" to the CNA about it. The behavior did not improve and the resident revealed s/he was "afraid" to bring it up again. 2. Review of the admission assessment dated 1/16/17 showed resident #21 had diagnoses	F 225		6/4/17

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F 225	Continued From page 15 which included cervicalgia (neck pain), and monoplegia (paralysis of 1 limb or region of the body) of the left lower limb and left upper limb. Further the resident was able to understand and be understood, and required total assistance of one person for bed mobility, transfer, and toilet use. The following concerns were identified: a. Interview with the resident on 4/4/17 at 9 AM revealed s/he reported concerns about staff and was told s/he "can go someplace else." Further, the resident revealed that CNA #2 was "rude" and "rough" when she provided care and the resident had expressed this to the nurses before. b. Review of a nurse's note dated 1/11/17 and timed 12:42 AM showed the resident reported s/he did not like the CNA "that was in here." The nurse talked to the resident 1 to 1 at that time. c. Review of a nurse's note dated 1/13/17 and timed 11:30 AM showed the resident had complained about care that was provided. The nurse told the resident s/he needed to express his/her concerns to the DON and "if [s/he] is not happy in this facility [s/he] could always consider another facility." d. Review of a nursing note dated 1/16/17 and timed 1:50 PM showed the resident reported that "aides" were not taking him/her to the bathroom during the shift and the previous night. Further, the note showed the CNAs stated the resident was visiting with family and the resident was taken to the bathroom after the visit. 3. Interview with the DON on 4/5/17 and timed 2:07 PM revealed she was not aware of any allegations related to resident treatment by CNA #2. Further she revealed an investigation had not been completed related to the allegations.	F 225		6/4/17

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F 225	Continued From page 16 4. Review of the policy titled "Patient Abuse/Unknown Cause of Injury Investigating/Reporting" last revised on 5/9/16 showed "...Abuse includes such actions as using derogatory language to a patient, rough handling, ignoring resident while giving care, directing patient who need toileting assistance to urinate or defecate in their bed, ignoring any request or need by a resident...2) Reporting: Any patient, family or staff who witness or suspect or have any concern about any resident who may be at risk of abuse will report such incident or concern to immediate floor supervisor on duty immediately. In the case of concern being related to immediate floor supervisor, another staff member may be notified. Immediate supervisor or staff member receiving report must determine most appropriate course of action for patient to ensure patient is removed from abusive situation immediately. Actions may include constant observation of patient by supervisor, staff perpetrator immediate suspension from cares, or other..." 5. Review of the employee file for CNA #2 showed a 6/3/03 date of hire and start date. Further review showed evidence CNA registry placement was requested; however, there were no results. In addition there was no evidence of a background check being completed. 6. Review of the employee file for CNA #4 showed a 5/26/16 date of hire and start date. Further review showed there was no evidence of a background check and reference check being completed. 7. Review of the employee file for RN #1 showed a 3/7/11 date of hire and start date. Further	F 225		6/4/17

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F 225	Continued From page 17 review showed there was no evidence of a background check and reference check being completed. 8. Interview with human resources on 4/5/17 at 2:30 PM revealed that she had only been there since May 2016. She also verified that the information on the three employees was not in the personnel files. 9. Review of the annual in-service for employees provided from HR showed a date of 1/26-1/28/16 for the facility's last annual employee abuse in-service. 10. Review of the policy and procedure titled "Employment Verification" last revised 5/20/16 showed the process for screening "...3) Copies of all background information will be kept in personnel files. 6) No person will be hired for a position prior to licensure verification, background check, and all previous employment history references. 7) Background checks will include all Federal and State required checks, and past job reference. 8) No person with a criminal background related to abuse or theft will be employed in this facility."	F 225		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 244	F244: This regulation will be met as evidenced by: A. Outstanding grievances from resident council meeting minutes will be resolved to include concerns expressed by resident #8.	6/4/17

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F 244	Continued From page 18 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and review of resident council meeting minutes, the facility failed to ensure resident grievances were resolved for 1 of 4 months (December 2016) reviewed. The findings were: 1. Review of the "Resident Council Meeting Minutes" dated 12/1/16 showed one of the residents was "tired" of his/her spouse's T-shirts getting lost. The spouse was also a resident at the facility. Review of the "Resident Council Meeting Minutes" Dated 3/2/17 showed Grievances from December 1, 2016 and listed the missing T-shirts with a plan of action as "communication book" and the grievance was marked as "resolved." 2. Group interview on 4/4/17 at 1 PM revealed 4 of 11 residents in attendance felt the facility was not providing feedback and resolution to their concerns. Further, the group felt missing clothing items continued be a concern. 2. Interview with resident #8 on 4/3/17 at 5:35 PM revealed s/he had been missing 23 T-shirts "for months now." 3. Interview on 4/6/17 at 9:10 AM with the housekeeping supervisor revealed if residents' clothing is missing the facility performs a search	F 244	1. Outstanding laundry issues to be reported to and investigated by Laundry Supervisor. 2. Clear mesh zipped laundry bags are on order for use for each residents clothing. 3. Laundry supervisor to educate staff on how to use these bags. 4. Nursing staff to be education on use of zipped bags that will be available for each resident. Quality Assurance: 1. Social Services or designee will have all grievances filled out on a grievance form and logged on the grievance log. This log will be monitored and	6/4/17

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F 244	Continued From page 19 for it and if it is not found the facility assumes it was sent out to a contracted cleaner. The facility attempts to call the vendor, however, "they usually destroy the clothing if it goes through their wash." Further, the vendor will return items found before they go through the wash, and these items belongings are given to activities so they can be reclaimed. Further, she stated social services "will replace the items if not found." 4. Interview on 4/6/17 at 9:48 AM with the social services director revealed the facility doesn't "replace clothing."	F 244	reported on quarterly at Quality Assurance Performance Improvement meeting. 2. Laundry supervisor to do random checks monthly on use of the laundry zipped bags and for misplaced or clothing and will report at	6/4/17
F 253 SS=E	483.10(l)(2) HOUSEKEEPING & MAINTENANCE SERVICES (l)(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 2 of 2 resident areas (100 hall, 200 hall) were clean and in good repair. The findings were: 1. Observations of the 100 hall beginning on 4/4/17 at 2:53 PM showed the following maintenance and housekeeping concerns: a. In the bathroom of room #101 the lower 7 inches on the door frames had chipped off paint exposing underlying material, which created a surface that could not be cleaned effectively. b. In room #104 the lower 12 inches of the door frame was damaged exposed underlying material which created a surface that could not be cleaned effectively. c. In room #109 the lower 23 inches of the	F 253	Quality Assurance Performance Improvement on a quarterly basis. F253 This requirement will be met as evidenced by: 1. a. Maintenance to paint all rooms and bathroom jams and lower walls where chipped and damaged. b. Maintenance to paint all rooms and bathroom jams and lower walls where chipped and damaged. c. Maintenance to paint all rooms and bathroom jams and lower walls where chipped and damaged. d. In the central bathroom, the laminate strip will be repaired on the cabinet.	

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F 253	Continued From page 20 door frame had chipped-off paint with exposed underlying material which created a surface that could not be cleaned effectively. d. In the toilet room next to the shower room the right side of the cabinet had 17 inches of broken trim which created a surface that could not be cleaned effectively. e. The entry to the 100 hall had three 4 foot by 2 foot ceiling tiles with black spots and holes in them. Two of the tiles also had small water spots on them. To the right by the wall there was a ceiling tile that had multiple cracks through it. f. The entry to the 100 hall had a 4 foot privacy wall with 3 spots with wallpaper peeled off. 2. Observation of the 200 hall beginning on 4/3/17 at 5:09 PM showed the following maintenance and housekeeping concerns: a. In room #206 in front of the bathroom the ceiling tile was cracked. b. The door frame at room #201 had chipped-off paint at the lower 12 inches that exposed underlying material which created a surface that could not be cleaned effectively. 3. Interview on 4/6/17 at 8:25 AM with the maintenance supervisor confirmed the identified areas needed to be fixed.	F 253	e. Ceiling tiles and floor tiles with any damage will be replaced. f. The privacy wall in the 100 hall will be repaired or replaced. 2. a. The ceiling tiles in room 205 will be replaced. b. The doorframe to room 201 will be repainted. Quality Assurance: Maintenance will do random monthly checks on hallways, rooms, door frames for cosmetic repairs and report quarterly at Quality Assurance Performance Improvement meeting.	6/4/17
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	F 309	F309 This requirement will be met as evidenced by: 1. Pain assessment to be completed for residents #17 and # 21 and resident will receive pain...	

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F 309	Continued From page 21 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (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. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interview, and medical record review, the facility failed to ensure pain monitoring was implemented for 3 of 3 sample residents (#17, #18, #21) with identified pain. Further, the facility failed to assess 1 of 3 sample residents (#12) after a fall. The findings were: 1. Review of the 3/27/17 significant change MDS	F 309	medications as ordered. (Resident #18 no longer in facility. 2. Pain assessments to be completed for all residents initially, quarterly, and prn. 3. A Safety Analysis to be completed for patient #12. 4. Safety Analysis will be completed on all residents initially, quarterly, and prn. 5. Nursing staff to educated on 5/18/2017: a. When administering prn pain medication to request a pain level and then after 60 minutes to reassess with documentation in the electronic medical record under the vital signs tab. b. All unwitnessed falls will require blood pressure, temperature, pulse, respirations, and neurological status evaluation every	6/4/17

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BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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F 309	Continued From page 22 assessment showed resident #17 had diagnoses that included arthritis, osteoporosis, and chronic kidney disease. Further the resident had a BIMS score of 15 (cognitively intact), was able to understand and be understood, had scheduled and as needed pain medication, and reported occasional pain of 7 out of 10. Review of the "Pain" care plan dated 8/31/16 showed approaches for pain included "1. Monitor pain 2. Non-drug interventions 3. Administer pain medications as ordered." The following concerns were identified: a. Review of a nursing note dated 3/29/17 and timed 2:14 PM showed the resident received an order for hydrocodone/acetaminophen (Norco) 5 mg (milligrams)/325 mg by mouth every 4 to 6 hours for pain for 2 weeks. Review of a nursing note dated 3/29/17 and timed 11:06 PM showed the resident complained of "generalized pain" at a level of 9 out of 10 and the norco was given. There was no evidence the medication effectiveness was assessed after administration. b. Review of the MAR for 2017 showed no evidence the resident was routinely assessed for pain. c. Interview with the resident on 4/5/17 at 1:50 PM revealed s/he did not think the CNAs always reported it to the nurse when s/he asked for pain medication, because sometimes s/he would not get any pain medication. d. Interview with a family member of the resident on 4/5/17 at 9:40 AM revealed the resident requested pain medication at night and the CNA would not tell the nurse. The resident had to wait until the next shift arrived to receive the medication. Further, the family member stated the resident would turn on his/her call light and staff would take more than an hour to answer it or turn the call light off without assisting the	F 309	shift for 72 hours post fall. c. Pain level to be assessed every shift and documented in vital sign portion of electronic medical record. Quality Assurance: Director of Nursing or Designee will monitor monthly pain levels for both scheduled and as needed pain medications in the electronic medical record and will report quarterly at Quality Assurance Performance Improvement meeting. 6/4/17	

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F 309	Continued From page 23 resident. 2. Review of the 2/13/17 admission MDS assessment showed resident #18 had diagnoses which included muscle weakness and low back pain. Further the resident had a BIMS score of 12 (cognitively intact), was able to understand and make self understood, and reported occasional pain of 6 out of 10. Review of the physician orders showed the resident received acetaminophen/oxycodone 325mg/10mg by mouth every 4 hours as needed for pain. The following concerns were identified: a. Review of the "Pain" care plan last reviewed on 2/13/17 showed approaches for pain included "1. Monitor pain 2. Non-drug interventions 3. Administer pain medications as ordered. 4. Establish causative factors and ways to alleviate them" b. Review of the MAR for 2017 showed no evidence the resident was routinely assessed for pain. 3. Review of the admission assessment dated 1/16/17 showed resident #21 had diagnoses which included cervicalgia (neck pain), monoplegia (paralysis of 1 limb or region of the body) of the left lower limb and left upper limb, and cardiovascular accident. Further the resident had a BIMS score of 6 (severely impaired), was able to understand and make self understood, received as needed pain medication, and reported occasional pain of 6 out of 10. Review of the physician orders showed the resident received acetaminophen 325 mg by mouth every 4 hours as needed for pain and acetaminophen/oxycodone 325 mg/10 mg by mouth every 4 hours for pain. The following concerns were identified:	F 309		6/9/17

DR 5/12/17

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F 309	Continued From page 24 a. Review of the "Pain" care plan last reviewed on 10/26/16 showed approaches for pain included "1. Monitor pain Chronic 2. Non-drug interventions Reposition, elevation, distraction 3. Administer pain medications as ordered." b. Review of the MAR for March 2017 showed no evidence the resident was routinely assessed for pain. 4. Interview with the DON on 4/5/17 at 2:07 PM revealed staff should assess residents' medication effectiveness after administering as needed pain medications; however, the facility did not routinely monitor residents for pain. 5. Review of a nurse's note dated 3/31/17 and timed 7 AM showed resident #12 was "found on [his/her] knees in [his/her] bathroom." The following concerns were identified: a. Review of the subsequent nursing notes showed no evidence the resident was monitored for injuries following the fall. Further, there was no evidence the resident was assessed for a possible head injury. b. Interview with the DON on 4/6/17 at 9:10 AM revealed the resident should have been monitored after the fall and neurological assessments should be completed after unwitnessed falls.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323	F323 This requirement will be met as evidenced by: 1. Resident #22 will be assessed for safety with transfers via the mechanical lift.	6/4/17

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F 323	Continued From page 25 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's instructions the facility failed to ensure 1 of 4 mechanical lift transfers observed were done safely (which affected resident #22). The findings were: 1. Observation on 4/4/17 at 10:39 AM showed a single CNA had used the sit-to-stand lift to assist resident #22 up out of a recliner to his/her wheelchair. 2. Interview with the DON on 4/6/17 at 8:40 AM revealed staff were expected to follow manufacturer's recommendations when using the mechanical lift. 3. Review of the "Lumex LF2020 Easy Lift Sit-to Stand" user manual copyright dated 2005 showed	F 323	2. All residents requiring transfers via mechanical lift will be assessed for safety initially, quarterly, and prn. 3. Nursing staff to be educated on 5/18/2017 on safe use of mechanical lifts in use and to follow manufactures recommendations. QA: Director of Nursing or Designee will assess quarterly and as needed each resident on safety of sit-to-stand mechanical lift and report to Quality Assurance Performance Improvement meeting.	6/4/17

JR 5/12/17

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F 323	Continued From page 26 "...2 Safety Precautions...Important: Before using patient lift, read and adhere to the following safety precautions and warnings. Failure to do so could result in serious personal injury or damage to your patient lift....Warnings...Warning: GF Health Products, Inc. strongly recommends that two caregivers take part in the lifting process..."	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the	F 329	F329 This requirement will be as evidenced by: 1. Consent forms are completed with target behaviors listed for all residents with initiation of psychotropic medication and includes resident #12 and #21. 2. Nursing staff to be educated on 5/18/2017 on need to complete Psychoactive Medication Monitoring for on electronic medical record every shift. 3. Psychoactive Medication Quarterly Review form will be completed on quarterly basis by Interdisciplinary Team.	6/4/17

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F 329	Continued From page 27 medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure behavior monitoring was implemented for 2 of 5 sample residents (#12, #21) who received psychotropic medications. The findings were: 1. Review of the 3/27/17 significant change MDS assessment showed resident #12 had diagnoses which included depression and manic depression, had a BIMS score of 13 (cognitively intact), had no evidence of delirium, and had a depression score of 0. Review of the physician orders showed the resident received Abilify (antipsychotic) 15 mg (milligrams) by mouth every day at bedtime, Lexapro (antidepressant) 20 mg by mouth every day, and clonazepam (antianxiety) 0.5 mg by mouth every day at bedtime. The following concerns were identified: a. Review of the medical record showed the facility had not identified specific target behaviors related to the medication use. Further, there was no evidence the facility was monitoring behaviors to identify or track the medication effectiveness. 2. Review of the 1/16/17 admission MDS assessment showed resident #21 had diagnoses which included cardiovascular accident and depression, had a BIMS score of 6 (severely	F 329	QA: Director of Nursing or designee will randomly monitor monthly the use of the Psychoactive Medication Monitoring form and report quarterly at Quality Assurance Performance Improvement meeting.	6/4/17

DB 5/12/17

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F 329	Continued From page 28 impaired), altered level of consciousness that fluctuated, and a depression score of 7 (mild). Review of the physician orders showed the resident received Abilify (antipsychotic) 5 mg by mouth every day, clonzepam (antianxiety) 0.5 mg by mouth twice per day, trazadone (antidepressant) 150 mg by mouth everyday at bedtime, and Zoloft (antidepressant)100 mg 2 tabs by mouth every day. The following concerns were identified: a. Review of the medical record showed the facility had not identified specific target behaviors related to the medication use. Further, there was no evidence the facility was monitoring behaviors to identify or track the medication effectiveness. 3. Interview with the DON on 4/5/17 at 2:07 PM revealed the facility does not do daily monitoring of behaviors for psychotropic medication use.	F 329		
F 371 S8=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371	F371: The regulations will be met as evidenced by: 1. All equipment in disrepair to include measuring pitchers/cups, Rubbermaid containers, and carafes were discarded and will be replaced with new items. 2. All food that was found to be outdated was discarded.	6/4/17

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F 371	Continued From page 29 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of cleaning logs, and policy and procedure review, the facility failed to ensure a sanitary environment in 2 of 2 food storage and preparation areas (main kitchen, dining room kitchenette). These failures related to out-dated food items, an unsanitary ice machine, and food service equipment in poor condition. The findings were: 1. Observation of the walk-in cooler on 4/3/17 at 4:43 PM showed shredded cheese in an opened bag dated 3/16. 2. Observation of the main kitchen on 4/3/17 at 4:45 PM showed two 3.9 liter measuring pitchers that were visibly discolored and stained yellow from use and could not be cleaned effectively. 3. Observation of a plastic storage closet in the main kitchen on 4/3/17 at 4:49 PM showed a plastic rubbermaid container that was cracked on the bottom which created a fissure that could not be cleaned effectively. 4. Observation of the dining room kitchenette on 4/3/17 at 5:05 PM showed the ice machine had a thick, white film around the dispenser opening. 5. Observation of the dining room kitchenette	F 371	3. Ice machine in kitchenette will be cleaned and maintained every week. 4. Dietary employees will be educated on how to identify and remove damaged equipment/utensils. Employees will also be educated on need to check on dated food daily with outdates discarded immediately. Quality Assurance: Dietary Manager or Designee will do monthly checks on all items and present logs quarterly at Quality Assurance Performance Improvement.	4/4/17

5/12/17

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F 371	Continued From page 30 refrigerator on 4/3/17 at 5:08 PM showed cheese slices with a use-by date of 3/28/17. 6. Observation of dinner service on 4/3/17 at 5:20 PM showed 6 of 17 water carafes in use had cracks and fissures which could not be effectively cleaned. 7. Observation of the walk-in cooler on 4/5/17 at 11:05 showed shredded cheese in an opened bag dated 3/16 and baby carrots in an opened bag with an "opened" date of 3/17. 8. Observation of the main kitchen equipment storage area on 4/5/17 at 11:08 AM showed an 8-ounce measuring cup with cracks and fissures and a 4-quart pitcher that was discolored, which could not be cleaned effectively. 9. Interview with the dietary manager on 4/5/17 at 11:15 AM revealed the food items were available for resident consumption and should have been discarded. Further, she confirmed the food containers were damaged and revealed they should have been replaced. 10. Review of ice machine cleaning log showed the dining room kitchenette ice machine was last cleaned on 7/18/16. 11. Interview with the maintenance director on 4/5/17 at 11:20 AM revealed he thought the ice machine had been cleaned more recently than 7/18/16 and the facility has issues with calcium build-up because of their water. Further, he confirmed the ice machine was visibly dirty. 12. Review of the policy titled "Food Preparation and Storage" issued 4/6/17 showed "...Policy:	F 371		6/4/17

5/11/17

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F 371	Continued From page 31 Foods shall be prepared, served, and stored in a clean and sanitary manner. Foods shall be prepared using clean, sanitized, and damage free cooking pans, preparation utensils, and the like [sic] Foods shall be served using clean, sanitized, and damage free tableware and the like [sic] Foods shall be stored in clean, sanitized, and damaged free containers...Damaged pans, preparation utensils, tableware, and storage containers shall be removed from use when surfaces have cracks, scratches, gouges, worn surfaces that are deemed incapable of being sanitized suitably..." 13. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days."	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 441	F441: This regulation will be met as evidenced by: 1) All staff will be in serviced regarding infection control, cross contamination, and disease spread at the next staff meeting on May 18, 2017.	4/4/17

KR 5/2/17

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F 441	Continued From page 32 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 441	Staff will review and sign linen transport policy at staff meeting on May 18. 2017. QA: Director of Nursing or designee will perform random observation of staff monthly to ensure infection prevention guidelines are being adhered to. To be reported quarterly at Quality Assurance, Performance Improvement meeting.	6/4/17

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F 441	Continued From page 33 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure infection prevention practices were followed during 1 random observation of linen handling and transportation. The findings were: Observation on 4/4/17 at 9:45 AM showed an unidentified CNA exited room 106 with unbagged linen held against her body, in her left hand. The CNA took the linen to the soiled utility room, discarded the linen, and then entered the clean utility room. The CNA obtained folded, unbagged, clean linen and carried it back to room 106. The CNA held the clean linen against her body in her left hand. Interview with the infection preventionist on 4/16/17 at 8:40 AM revealed linen should be bagged during transportation and carrying unbagged soiled linen in the hallway was not acceptable. Further the clean linen could have been contaminated because it came in contact with the same area on the staff member as the soiled linen.	F 441		6/4/17

JF 5/12/17

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535019	A. BUILDING _____ B. WING _____	C 04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	366 SOUTH US HWY 20 BASIN, WY 82410

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F 514 F 514 SS=F	Continued From page 34 483.70(l)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (l) 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 (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 and staff	F 514 F 514	F514 This requirement is met as evidenced by: A. The electronic medical record is "rolled" at the end of each month for ease in accessing current information. 1. Employees will be instructed on how to access complete medical record which is readily available and will include the original date of admission or when facility started using the electronic medical record 12/12. 2. All users who are not familiar with the use of the electronic medical record will receive training on how to readily access current as well as past information from electronic medical record. 3. A user manual will be available for use by users as needed. QA: Director of Nursing or designee will have licensed staff access at random information from the electronic record and report quarterly	6/4/17

SB 5/12/17

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F 514	Continued From page 35 Interview, the facility failed to ensure a complete, systematically organized electronic health record for each resident was accessible. The census was 25. The findings were: 1. Interview with the administrator during the entrance conference on 4/3/17 revealed that the facility was using an electronic health record (EHR) system for the resident records. The following concerns were identified: a. During the survey, the surveyors identified issues trying to access and review the residents' medical records. The surveyors were involuntarily logged out of the system on multiple occasions and had to ask staff for copies of the residents' medical record or parts of the records in order to complete the survey. b. Review of individual resident records showed that all residents had an admission date of 4/1/17. Further, all physicians orders had a start date of 4/1/17. c. Interview with LPN #1 on 4/4/17 at 3:50 PM revealed she had to "fight" with the computer system because it would freeze and log out. d. Interview with the DON on 4/4/17 at 4:20 PM revealed all residents showed an admission date of the first day of the current month because the computer system "rolls over" every month related to computer memory issues. Further, she revealed in order to identify the correct admission and physician order dates, every month had to be accessed and reviewed. e. Interview with the administrator on 4/5/17 at 1:41 PM revealed the computer system "is not the best" and it frequently "kicks you out." Further, it was revealed the facility had identified the concern and was working with some companies to change the system; however, there was not a date the system would be changed.	F 514	at Quality Assurance Performance meeting.	6/4/17

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F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520	F520: This regulation will be met as evidenced by: a) Quality Assurance project for Abuse Investigations will be initiated by date of next Quality Assurance meeting on May 11, 2017. b) Quality Assurance project for grievances will be initiated by date of next Quality Assurance meeting on May 11, 2017. c) Social Services director will meet with Quality Assurance Director monthly to discuss Quality Assurance projects. QA: Quality Assurance Director will perform random monthly checks of abuse and grievance logs to ensure concerns are being addressed in a timely fashion, and logged as indicated. To be reported quarterly at Quality Assurance, Performance Improvement meeting.	6/4/17

5/12/17

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F 520	Continued From page 37 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined that the facility did not have a Quality Assessment and Assurance (QAA) committee that identified concerns, developed and implemented action plans to correct the concerns, and monitored the facility's effectiveness to maintain a minimum standard of care for residents residing in the facility. The facility census was 25. The findings were: 1. A review of the QAA (Quality Assessment & Assurance) program was done on 4/6/17 at 9:33 AM with the ADON. The areas identified for performance improvement by the facility included abuse investigations, and grievances. The following concerns were identified: a. The facility identified abuse investigations as an area in need of improvement. Since this identification, the facility failed to ensure identified allegations were investigated as referenced in F225. b. The facility identified the grievance procedure as an area in need of improvement. The identified problem was resident/family grievances were not being recorded and the plan included a log being kept to record all grievances turned in by residents and family. The facility failed to ensure identified grievances were logged and resolved as referenced in F166. c. Interview with the ADON on 4/6/17 at 9:33 AM confirmed the the QAA program was not effective related to abuse identification and investigation, and grievance identification and resolution.	F 520	6/4/17	