PRINTED: 08/03/2017
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 from 7/17/17 to 7/20/17. Also reviewed in the course of the survey was complaint intake WY000002407. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing Services MAR- Medication Administration Record MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 166 SS=B	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 regarding the residents' rights contained in this paragraph. Upon request, the provider must give	F 166		

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

NHA 8/24/17

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.

AUG 24 2017

Accepted 8-25-17 DOC 8/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 166	Continued From page 1 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 investigated;	F 166	F166 The Facility will ensure that the grievance policy will contain all required information including; a) The policy will state the Grievance official's contact information which will include phone number, address and email address. The policy will state the time frame for completion of the grievance filed. The policy will also state the resident's right to file anonymously. b) The facility will post the policy on the bulletin board located by the dining room and given to residents annually at their care conferences. c) DON or designee will in-service staff on the grievance policy and location of policy within the facility. d) The grievance policy will be reviewed by QAPI to ensure correction is achieved and sustained and evaluated for efficacy for 2 months or until resolved. Will audit to ensure the policy will state or provide the contact information which will include the phone number, address and email of the Grievance Official. The policy will state the time frame for completion of the grievance filed. The policy will also state the resident's right to file anonymously. The audit will also include auditing the posting of the policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 166	Continued From page 2 (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 review of policy and procedure and staff interview, the facility failed to ensure the grievance policy contained all required information. The census was 57. The findings were:	F 166	F166 (cont) on the bulletin board and given to residents annually at their care conferences. An all staff in-service will also be done on the grievance policy and location of the policy within the facility. Results will be monitored for two months at QAPI or until resolved.	08/20/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 166	Continued From page 3 Review of the policy and procedure entitled "Grievance/Complaint Log," last updated 6/14/17, showed the policy failed to contain all required information including the contact information of the grievance official, the expected timeframe for completion of the grievance, and the contact information of independent entities with whom a grievance could also be filed. Further, the policy did not address the residents' right to file a grievance anonymously. Interview with the social worker on 7/19/17 at 5:10 PM confirmed the policy did not contain the required information.	F 166		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, the facility failed to promote dignity during 1 random observation with resident #9. The findings were: 1. Observation on 7/17/17 at 12:33 PM showed 2 CNAs attempting to assist resident #9 in a chair up to the dining room table. When the attempt was unsuccessful the CNAs left the room and returned within 2 minutes with CNA #1. CNA #1 came into the dining area and went directly to the resident and told him/her that she was going to	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4 move him/her up to the table on the count of 3. As the aide started counting "1, 2" she moved the resident quickly up to the table, and "3," she smiled at the resident and left the dining room. 2. Interview with the resident on 7/19/17 at 10:55 AM revealed s/he was only at the facility to get stronger. The resident stated some days the staff treated him/her with respect and "some days no they don't." The resident stated CNA #1 "is always rough handling me...she's their muscle man." 3. Interview on 7/20/17 at 9:22 AM with the DON stated that staff are trained to treat residents with dignity. She further stated dignity concerns may be treated the same as an abuse allegation.	F 241	F241 The facility will promote dignity and respect of individuality with all residents. a) Resident #9 will be given time as staff directs before being repositioned and staff will be respectful and promote dignity. b) All residents will be repositioned on the count stated by staff to be respectful and promote dignity. c) DON or designee will in-service staff on respect and dignity of all residents. d) All residents will be treated with dignity and respect and this will be audited and taken to QAPI for monitoring for 2 months or until resolved.	08/20/17
F 242 SS=B	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, and staff and resident	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 242	Continued From page 5 interview, the facility failed to ensure residents were provided a choice related to coffee. The census was 57. The findings were: Observation on 7/17/17 at 4:50 PM showed the coffee available in the main dining room was labeled as decaffeinated. Interview with cook #1 at that time revealed there was regular coffee in the employee lounge, but residents were only provided decaffeinated coffee. The cook then stated they had never offered regular coffee to residents that he was aware of. Interview with resident #20 on 7/20/17 at 9:29 AM revealed s/he liked to have a cup of coffee in the morning and preferred it to be regular, not decaffeinated. Interview with resident #11 on 7/20/17 at 9:32 AM revealed s/he liked to drink coffee during the day. S/he stated there were times when his/her choice was regular, and times when decaffeinated was better. She stated, "I think I get a choice."	F 242	F242 The facility will ensure residents have the right to make choices. a) Resident #20 will be given a choice on the menu between decaffeinated and caffeinated coffee. b) Resident #11 will be given a choice on the menu between decaffeinated and caffeinated coffee. c) All residents will be given a choice on the menu between decaffeinated and caffeinated coffee. d) Residents will be given a choice on their daily menus of coffee, decaffeinated or caffeinated. DON or designee will in-service staff regarding the resident's preferences.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279	e) Coffee choices will be monitored via Resident Council and care plans and results taken to QAPI for two months or until resolved.	08/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 279	Continued From page 6 (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 279	Continued From page 7 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, incident review, and staff interview, the facility failed to ensure a comprehensive care plan with meaningful interventions was developed based on resident needs for 2 of 13 sample residents (#40, #54). The findings were: 1. Review of the 4/16/17 significant change MDS assessment for resident #40 showed the resident had diagnoses which included Alzheimer's disease and non-Alzheimer's dementia and had a BIMS score of 2/15 (severe cognitive impairment). The resident required limited assistance of 1 staff member for transfers and locomotion. Review of a facility event report dated 5/2/17 showed the resident had an unwitnessed fall in the dining room of the secure unit when s/he stood up and walked to the drink cart. The resident fell against the drink cart which resulted in a right wrist fracture and 8 sutures above the right eye. Review of the care plan dated 5/4/17 in the category of falls showed an intervention of "My staff will be reminded that the drink cart can not (sic) be left in the dining room when not being used." 2. Review of the significant change MDS assessment with an assessment reference date of 10/13/16 showed resident #54 had diagnoses that included non-Alzheimer's dementia, TIA	F 279	F279 Development of comprehensive care plans will have meaningful interventions and will be specific to resident needs. a) Resident #40 will have a meaningful intervention put in place. b) Resident #54 will have a meaningful intervention put in place. c) All residents with current fall care plans will be reviewed by the fall committee and evaluated for resident needs and appropriate interventions and changed as needed. d) All residents will have care plans developed with meaningful and purposeful interventions that are resident specific as soon as possible and fall committee will meet weekly to discuss whether the intervention is appropriate or not for that individual resident. e) DON or designee will in-service all staff on developing comprehensive care plans based on resident's needs and appropriateness based on resident condition and disease process. f) COTA or designee will monitor and audit efficacy of the interventions placed and results will be taken to QAPI for 2 months or until resolved.	08/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 279	Continued From page 8 (transient Ischemic attack), and anxiety disorder. The resident required the extensive physical assistance of two persons for ADLs such as bed mobility and transfers, the extensive assistance of one person for toileting, and the supervision of one person for locomotion. Further review revealed the resident was always incontinent of bladder and had a BIMS score of 3/15 (severe cognitive impairment). Review of the 5/23/17 significant change MDS assessment showed the resident required the extensive assistance of one person for locomotion. The following concerns were identified: a. Review of the event report dated 11/15/16 at 11:08 PM showed the resident fell in the bathroom and fractured his/her left hip. Further review of event reports showed the resident continued to have repeated falls, one of which resulted in a fractured right hip on 5/26/17. b. Review of the resident's care plan in the category of falls showed no evidence interventions were developed or implemented after the November 2016 fracture. Review of the progress notes revealed the housekeeping supervisor had been educated "about replacing [non-slip] strips after waxing floor" and "strips replaced." c. Review of the facility event report showed on 5/26/17 the resident was witnessed getting up out of his/her wheelchair in the hallway and attempted to walk. The resident tripped and fell which resulted in a fracture to his/her right hip. Review of the fall committee report dated 6/1/17 showed "Will place interventions upon [his/her] readmission to [nursing facility name]." Review of the care plan in the category of falls showed no evidence interventions were developed or implemented after the fall with major injury.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 279	Continued From page 9 3. Interview with the DON on 7/19/17 at 10:50 AM confirmed the care plans were not updated to show interventions after these falls.	F 279		
F 323 SS=G	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 (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, medical record review, review of manufacturer's instructions, and staff interview, the facility failed to develop and implement interventions to prevent and minimize falls for 1 of 6 sample residents (#54) reviewed	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 for falls. This failure resulted in harm to resident #54 who sustained 2 separate hip fractures. In addition, the facility failed to assess the safety of bed wedges for 3 of 6 sample residents (#3, #19, #54) who were at risk for falls. The findings were: Review of the significant change MDS assessment with an assessment reference date of 10/13/16 showed resident #54 had diagnoses that included non-Alzheimer's dementia, TIA (transient ischemic attack), and anxiety disorder. The resident required the extensive physical assistance of two persons for ADLs such as bed mobility and transfers, the extensive assistance of one person for toileting, and the supervision of one person for locomotion. Further review revealed the resident was always incontinent of bladder and had a BIMS score of 3/15 (severe cognitive impairment). Review of the 5/23/17 significant change MDS assessment showed the resident was severely cognitively impaired and wandered 4 to 6 days during the 7 day look back period. The resident required the extensive physical assistance of two persons for ADLs such as bed mobility, transfers, and toileting and the extensive assistance of one person for locomotion. Review of the event report dated 11/15/16 at 11:08 PM showed the resident fell in the bathroom and fractured his/her left hip. Further event reports showed the resident continued to have repeated falls which included a fall on 5/26/17 that resulted in a fracture to the right hip. Observation during the survey on 7/17/17 at 4:10 PM showed the resident used a Merry Walker (a rolling walker with a seat and framework that surrounds the person) to ambulate around the secure unit and was at times out of sight of staff. In addition, observation on 7/19/17 at 1 PM showed the resident was in	F 323	F323 The facility will ensure residents will have the least restrictive devices placed and to develop and implement interventions to prevent and minimize falls. Resident's will have adequate supervision that will be posted on facility staffing sheet. a) Bed wedges were removed for resident #54. b) Bed wedges were removed for resident #3. c) Bed wedges were removed for resident #19. d) DON or designee will in-service all staff that no bed wedges will be used in the facility. e) Resident #54 will be assessed for all current and future safety interventions in efforts to reduce future falls. All future fall interventions will be assessed for safety. f) Resident #3 will be assessed for all current and future safety interventions in efforts to reduce future falls. All future fall interventions will be assessed for safety. g) Resident #19 passed away.	

PRINTED: 08/03/2017
FORM APPROVED
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1109 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 bed with a wedge in place along the edge of the bed. The following concerns were identified: a. Review of the resident's care plan in the category of falls showed no evidence interventions were developed or implemented after the November 2016 fracture. Review of the progress notes revealed the housekeeping supervisor had been educated "about replacing [non-slip] strips after waxing floor" and "strips replaced." b. Review of the facility's event reports showed the resident had an unwitnessed fall on 11/26/16 at 2:30 PM while attempting to self-transfer out of his/her recliner. The resident was "unresponsive for approximately 8 minutes" and taken by ambulance to the hospital. Review of a nurse's note dated 11/26/16 and timed 5:45 PM showed the resident "needs assistance for all ADLs. Supervision when eating. Uses a wheelchair for mobility pushed by staff to dining room ...Uses sit to stand for transfers." However, review of the care plan in the category of falls showed no evidence interventions were developed or implemented after the incident. c. Review of the facility's event reports showed the resident had an unwitnessed fall on 11/30/16 at 5:30 AM when s/he "woke up became restless, having confused orientation and extremely poor self-safety awareness, attempted to get up without assistance." Review of a nurse's note dated 11/30/16 and timed 7 PM showed the resident was placed in the dining room with 1 to 1 staff monitoring. On 12/1/16 at 1:29 PM the fall committee recommended "will check for possible UTI (urinary tract infection)" and further "will remove air mattress to see if that's what's (sic) causing [the resident] to get OOB (out of bed) and reposition self and or sliding off bed." Review of the care plan in the category of falls showed no	F 323	F323 (cont) h) IDT will discuss and evaluate safety appropriateness and effectiveness of interventions at weekly meetings and document. i) COTA or designee will audit the efficacy of the interventions placed and bring results to QAPI for 2 months or until resolved.	08 /20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

evidence interventions were developed or implemented after the incident.

d. Review of a nurse's progress note dated 12/14/16 and timed 11:38 AM showed the resident had to be redirected several times by staff because s/he was attempting to transfer. The resident required staff assistance of 2 with transfers and ADLs, and was able to "wheel self around in the unit, but staff will wheel resident to the dining room for meals." Review of the facility's event reports showed the resident had an unwitnessed fall on 12/15/16 at 8:33 PM when s/he attempted to self-transfer out of the recliner, which resulted in a skin tear to his/her left elbow. On 12/18/16 at 8:28 PM the resident had an unwitnessed fall when s/he attempted to self-transfer out of his/her bed. Review of the care plan in the category of falls showed no evidence interventions were developed or implemented after the incidents. Review of the fall committee report dated 12/22/16 showed "We will schedule a pain med in the evening to help alleviate [the resident's] restless and discomfort from recent hip surgery."

e. Review of the facility's event report showed the resident had a witnessed fall on 12/24/16 at 11:30 AM when s/he "climbed out of the recliner in the dining room and attempted to walk." Review of the fall committee report dated 12/29/16 revealed "Will get an evaluation from therapies to put the resident in a Merry Walker." Review of the care plan in the category of falls showed no evidence interventions were developed or implemented after the incident.

f. Review of the facility's event reports showed the resident had an unwitnessed fall on 12/31/16 at 1:05 AM when s/he was found lying next to his/her bed. An unwitnessed fall occurred on 1/6/17 at 3 PM when the resident attempted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

self-transfer from the bed to the Merry Walker. An unwitnessed fall occurred on 1/9/17 at 7:40 PM when the resident attempted to self-transfer from his/her bed which resulted in a skin tear to his/her left elbow. The fall committee report dated 1/12/17 determined the fall which occurred on 12/31/16 was not a fall because the "resident wanted to lay on the floor and is care planned to do so as of 9-29-16." It was the recommendation of the committee to remove the Merry Walker from the resident's room when it was not in use. This intervention was noted in the resident's care plan.

g. Review of the facility's event report showed the resident had an unwitnessed fall on 1/27/17 at 12 PM when s/he was in the dining room sitting at a table in a chair when s/he attempted to get up and sat on the floor. The fall committee report dated 2/2/17 recommended the resident be transferred from the Merry Walker to the dining room chair after the meal tray was served and then transferred back to the Merry Walker after the meal was completed. Review of the care plan in the category of falls showed no evidence interventions were developed or implemented after the incident.

h. Review of the facility event report showed on 3/9/17 at 5:30 AM the resident was found sitting on the floor beside the bed. The resident's bed was in the low position and the resident had climbed over the wedge. The fall committee determined this was not a fall as s/he was care planned to sit on the floor. The safety of the wedge was not addressed.

i. Review of the facility event report showed on 3/19/17 at 3:10 PM the resident attempted to lay down on the couch in the dining room while in the Merry Walker. The incident was unwitnessed. The resident had a small abrasion on his/her left

PRINTED: 08/03/2017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 shin. On 3/23/17 at 6 PM the resident attempted to self-transfer to his/her bed while still in the Merry Walker. The incident was unwitnessed. The fall committee determined on 3/23/17 staff would offer to help lay down after meals. This was added to the care plan in a note dated 3/23/17. On 3/27/17 at 7:30 AM the resident attempted to self-transfer from the Merry Walker to the bed. This incident was witnessed by Helping Hand #1 (an unlicensed aide). The fall committee determined on 3/30/17 the resident should be referred to therapy to evaluate for Merry Walker safety. Review of a PTA (physical therapy assistant) note dated 3/31/17 revealed the resident was "deemed safe in shorter merry walker." j. Review of facility event reports showed the resident had additional unwitnessed falls while in his/her Merry Walker. On 5/4/17 at 6:35 PM the resident went into another resident's room and closed the door. The resident was found on the floor and had crawled out of the Merry Walker. On 5/13/17 at 3:45 PM the resident was able to open the front of the Merry Walker while in the dining room and step out of it. The resident was found on his/her hands and knees with the Merry Walker tipped over on its side. On 5/13/17 at 9:25 PM in the dining room lying on his/her back with the Merry Walker tipped over. Review of an event report dated 5/16/17 at 9:45 AM showed the resident was found "laying backwards of the floor in [his/her] merry walker with [his/her] head against the heat register." Review of the fall committee report dated 5/11/17 showed the recommendation was to have staff evaluate the resident for a different Merry Walker. The next fall committee report was dated 5/18/17 showed the resident was taken out of the Merry Walker, returned to a wheelchair, and started on an	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1109 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15	F 323		

antibiotic for a urinary tract infection (14 days after the 5/4/17 incident in the Merry Walker). A care plan dated 5/18/17 showed no evidence of any further interventions related to this series of falls.

k. Review of an event report showed on 5/19/17 at 10:35 AM the resident had an unwitnessed fall when s/he attempted to self-transfer from the wheelchair to the bed. On 5/21/17 at 7:40 PM the resident was witnessed being in an agitated state and tried to pull the "side rail" off the wall which resulted in the wheelchair tipping over with the resident in it. On 5/26/17 at 8:10 PM the resident was witnessed "getting up out of [his/her] wheel chair and walking, them (sic) tripped and fell and landed on [his/her] right side. This fall resulted in a right hip fracture. The fall committee report dated 6/1/17 showed "Will place interventions upon [his/her] readmission to [nursing facility name]." Review of the care plan in the category of falls showed no evidence interventions were developed or implemented after this fall with major injury.

l. Review of the facility event reports showed the resident had unwitnessed falls on 6/18/17, 6/20/17 and 6/21/17. The fall committee report dated 6/22/17 showed no interventions were implemented. Staff were to check for a UTI and assess for pain.

m. Review of an event report showed on 6/25/17 at 11 AM the resident attempted to get out of his/her wheelchair in the dining room and sat on his/her bottom which resulted in a skin tear to his/her left elbow. A "Butterfly Chest Harness" was placed as an immediate intervention and staff were educated.

n. Review of an event report showed on 7/3/17 at 4 PM the resident was outside in the courtyard in his/her wheelchair. S/he fell forward

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16	F 323		

out of the wheelchair and struck his/her forehead on the cement patio. The report showed the resident was not wearing the harness. This fall was witnessed by 2 non-licensed staff, Helping Hands #2 and #3. The report failed to contain details in regard to how many residents were in the courtyard and how many total staff members were present. The fall committee report dated 7/6/17 revealed the resident was not wearing the harness because s/he continued to remove it. The intervention recommended was to attach the harness to the wheelchair. Review of a nurse's note dated 7/9/17 showed the Butterfly chest harness was discontinued. Review of the manufacturer's instructions for the harness showed; "Important Notice This is not a safety device. It is to be used only for positioning. It must be used in conjunction with a metal seat belt!" Interview with the DON on 7/19/17 at 1:13 PM verified there was no seatbelt used in conjunction with the harness.

o. Review of an event report showed on 7/6/17 at 10 PM the resident crawled out of bed, over the bed wedge, and crawled across the room. The resident complained of mild back pain and sustained a laceration to his/her left elbow. The immediate interventions on the report showed the resident was placed in the wheelchair with the harness on and was provided one on one supervision. Review of the care plan showed there were no interventions or updates related to this fall.

p. Review of in-service training reports showed staff were informed on 2/2/17 to keep the resident in the Merry Walker until the meal was served and then transfer back to the Merry Walker immediately after the meal was completed. On 3/23/17 staff were directed to offer to help the resident lay down after meals to help

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1109 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 prevent falls; on 6/5/17 for hip precautions; and on 6/25/17 staff were educated on the Butterfly chest harness. q. Interview with the DON on 7/19/17 at 10:50 AM confirmed the care plan did not contain clear interventions. the DON further stated the facility did not provide 1 on 1 supervision. r. Interview with the administrator on 7/20/17 at 10:33 AM revealed the fall committee meets once a week on Thursdays. She stated it was recently suggested by the DON that it should meet more often. s. Interview with the restorative services manager on 7/20/17 at 11:45 AM revealed additional documentation from the original incident reports was not available. She stated the hand-written reports were shredded after the electronic event report was closed. Related to bed wedge assessments for safety: 1. Review of the 5/23/17 significant change MDS assessment for resident #54 showed the resident had severe cognitive impairment. The resident required the extensive assistance of two persons for ADLs such as bed mobility and transfers. Observation on 7/19/17 at 1 PM showed the resident was in bed with a wedge located on the outside edge of the bed and underneath the fitted sheet. Review of the facility event report dated 3/9/17 at 5:30 AM showed the resident had climbed over the wedge and was found on the floor. An event report dated 7/6/17 at 10 PM showed the resident had crawled out of bed, over the wedge, and across the floor. The resident complained of mild back pain and sustained a laceration to his/her left elbow. Review of the medical record failed to show any assessment related to the safety of the bed wedge device.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 2. Review of the 6/15/17 quarterly MDS assessment showed resident #3 had severe cognitive impairment, and was not steady during transfers and walking. Observation on 7/17/17 at 11:53 AM revealed a wedge secured under the fitted sheet on the outside edge of the resident's bed. Review of the care plan showed on 4/13/16 the facility had "placed bilateral positioning bars with covers and a bed wedge on the resident bed to define the bed parameters." Review of the care plans showed on 8/18/16 the resident fell out of bed with the wedges in place. Interview with the DON on 7/18/17 at 3:10 PM stated "the resident came from another facility with the wedge and the family wanted them continued here." She further verified there was no safety assessment of the device completed initially or after the fall. 3. Review of the 5/4/17 quarterly MDS assessment showed resident #19 was cognitively intact with a BIMS score of 14/15. The resident required extensive assistance for ADLs, had no range of motion impairments, and was not steady during transfers or walking. Observation on 7/17/17 at 2:32 PM showed a wedge device was affixed to the outside of the resident's bed. The wedge was secured under the resident's fitted sheet. Review of the updated fall care plan last revised on 5/11/17 showed the resident had a fall over the wedge on 12/1/16. The "resident crawled over bed wedges and fell to the floor and bumped head." Review of the medical record failed to show any assessment related to the safety of the bed wedge device. 4. Interview with the DON on 7/18/17 at 3:10 PM revealed there were no safety assessments completed for the wedges. They were used as	F 323		

PRINTED: 08/03/2017
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 interventions for falls. Interview on 7/18/17 at 3:29 PM with the administrator revealed the wedges were positioned under the fitted sheet for patient comfort and to prevent falls. 5. Review of the manufacturer's instructions showed the wedge/bolster was "removable/adjustable to increase the ease of patient bed exit ...place soft rails on top of the mattress with quick-release buckles away from the resident. Warning - this device is not a substitute for side rails or other protective devices for patients at risk of injury from falls due to unassisted bed exit."	F 323		
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides.	F 356		

PRINTED: 08/03/2017
FORM APPROVED
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 356	Continued From page 20 (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of daily staff postings, the facility failed to ensure the nurse staff posting met all required elements for 4 of 4 days reviewed in July 2017 (7/17, 7/18, 7/19, 7/20). The findings were: 1. Observation of daily staff postings from 7/17/17 to 7/20/17 showed the following elements were missing: a. The total and actual hours worked for the RN, LPN and CNAs. b. The posting information was not visible.	F 356	F356 The facility will ensure to post all required elements related to nurse staff postings. a) Total and actual hours worked for RN, LPN, Med Aides and CNA's will be a clear and readable format. b) Nursing hours will be visibly posted for all residents and staff to see in a prominent place readily accessible to residents and visitors. c) DON or designee will in-service all RN's and LPN's on how to fill out and visibly post the form. d) Will bring audit to QAPI to ensure that the forms are fill out completely and correctly. NHA, DON or designee will take results to QAPI for 2 months or until resolved.	08/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 356	Continued From page 21 The daily sheets were placed on a clip board which was tucked into a black wall-mounted file holder by the DON's office making it difficult to see or find. 2. Interview with the administrator on 7/20/17 at 10 AM confirmed the actual hours and total hours for each category of staff were not included.	F 356		
F 367 SS=E	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the menu, and a resident diet order list, the facility failed to ensure the mechanical soft diet texture was followed during 1 of 1 meal service observations (the 7/19/17 evening meal). The census of residents with mechanical texture diets was 17 (#1, #2, #6, #7, #12, #13, #15, #18, #21, #27, #30, #32, #34, #40, #55, #56, #57). The findings were: Review of the menu for the evening meal on 7/19/17 showed those with orders for a mechanical soft diet texture were to have 1/2 cup of the vegetable of the day. Observation of the meal service on 7/19/17 beginning at 4:42 PM	F 367		

PRINTED: 08/03/2017
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 367	Continued From page 22 showed residents #56 and #40 had diet cards that showed orders for mechanical soft texture. Both were served tossed salads with their meal which consisted of raw lettuce and tomato. Review of the list provided by the dietary manager on 7/20/17 showed in addition to these 2 residents, there were 15 other residents in the facility who had diet orders for a mechanical soft texture. These 15 residents were: #1, #2, #6, #7, #12, #13, #15, #18, #21, #27, #30, #32, #34, #55, #57. Interview with the dietary manager on 7/20/17 at 8:30 AM verified the menu should have been followed and these residents should have been provided the texture that was ordered for their diets, a cooked vegetable of the day, rather then the raw salad.	F 367	F367 The facility will ensure to follow the mechanical soft diet texture. a) Resident #56 will be served mechanical soft diet texture. b) Resident #40 will be served mechanical soft diet texture. b) All residents with mechanical soft diet texture will be followed. c) Dietary Manager or designee will in-service all staff on following resident's dietary cards.	
F 371 SS=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	d) All residents with a mechanical soft diet will be monitored twice a week by DM or designee to ensure the mechanical soft diet is received. Results will be taken to QAPI for 2 months or until resolved.	08/20/17

PRINTED: 08/03/2017
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 371	Continued From page 23 (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 and staff interview the facility failed to ensure sanitary conditions were met related to cleanliness of equipment and hand washing techniques in 1 of 1 kitchen. The findings were: 1. Observation on 7/17/17 at 11:25 AM in the kitchen showed the hood vents above the range and fryer unit were soiled with grease and dust build-up. The two conventional ovens were soiled with burned-on food in the interiors. The microwave oven was soiled with splattered and spilled food debris on the interior walls of the oven. In addition, it was noted the cutting board surface attached to the steam table unit was discolored and scored from use. Observation on 7/19/17 at 4:33 PM showed these items remained in the same unclean condition. 2. Observation on 7/17/17 at 2:34 PM showed the interior of the ice machine was soiled with a whitish and yellowish build-up on the plastic piece that was located above the ice in the bin. 3. Observation of the evening meal service on 7/19/17 at 4:42 PM showed dietary staff member #4 entered the kitchen and failed to perform hand washing before proceeding with various clean-up tasks in the kitchen. Additionally, at 4:48 PM	F 371	F371 The facility will ensure sanitary conditions will be met related to cleanliness of equipment and hand washing techniques in the kitchen. a) Hood vents above the range and fryer unit, conventional oven, microwave oven, steam table cutting board will be cleaned. b) The ice machine will be cleaned per manufacturer's instructions. c) DON or designee will educate Dietary staff member #4 on proper hand washing techniques at appropriate times. d) Dietary Manager/RD or designee will in-service all kitchen staff on proper equipment cleaning. e) NHA or designee will educate Maintenance on proper cleaning of the ice machine. f) DON or designee will in-service all kitchen staff on proper hand washing techniques at appropriate times. g) Dietary Manager or designee will monitor proper cleanliness of equipment and hand washing techniques per random observation in the kitchen. Results of this will be taken to QAPI for 2 months or until resolved.	08/20/17

PRINTED: 08/03/2017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 371	Continued From page 24 dietary staff member #4 handled the walk-in freezer door and, without washing her hands, donned gloves to handle resident food. 4. Interview with the dietary manager on 7/20/17 at 8:30 AM revealed they were down a couple of positions in the department and were in the process of hiring and training. Due to this the cleaning had not been done as planned. The dietary manager also verified the staff were expected to wash their hands prior to gloving. 5. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 6. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 371		