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
	535025	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 7/31/17 through 8/3/17. Also reviewed in the course of the survey were complaint intakes WY000002443, WY000002444, and WY000002445. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living BIMS: Brief Interview for Mental Status CMS: Center for Medicare and Medicaid Services CNA: Certified Nurse Aide DON: Director of Nursing Services LPN: Licensed Practical Nurse MDS: Minimum Data Set RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility's allegation of compliance.	
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	F 167	**F 167** **Corrective Action** The NHA posted a notice on 8/3/17 indicating that 3 years of survey are available in for review upon request. The information has been available since that time. **Identification of Others** There is only one area where this is posted in the facility. **Systemic Change**	8/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Hancock | TITLE: NHA | (X6) DATE: 8/25/17

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.

Accepted with Change on pg. 13

per conversation with Brenda Hancock NHA on 9/11/17

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F 167	Continued From page 1 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 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 staff interview, the facility failed to ensure a notice of the availability of surveys for the preceding 3 years was posted as required. The resident census was 93. The findings were: Observation on 8/1/17 at 9:45 AM showed the results from surveys completed from April 2016 through 5/11/17 were available in a binder by the main entrance to the facility. Further observation showed there was no notice posted to let individuals know all survey results from the preceding 3 years were available for review upon request. Interview with receptionist #1 on 8/3/17 at 8:20 AM confirmed the facility had no survey results available before April of 2016, and no information was posted to inform the public that surveys prior to April of 2016 could be provided by the facility for review. She further stated that the facility was unaware of that requirement.	F 167	In-service training was provided to the NHA by the District Director of Clinical Services on 8/1/17 regarding the requirement to have 3 years of survey results available and a notice posted to let individuals know the information is available. **Monitoring** The NHA checks the survey results binder monthly to ensure that the results are available and the notice is correctly posted. The NHA reports any concerns or patterns to the Quality Assessment Performance Improvement Committee monthly for their review. These checks will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 250	483.40(d) PROVISION OF MEDICALLY	F 250	**F 250** **Corrective Action** Physical Therapy evaluated resident #1's ability to use the electric wheel chair on 8/17/17. The findings indicated	8/31/17

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F 250 SS=D	Continued From page 2 RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure medically-related social services were provided related to wheelchair needs for 1 of 1 sample residents (#1) with these needs. The findings were: Observation on 8/1/17 at 9:40 AM showed resident #1 had an electric wheelchair in his/her room; however, the resident used a manual wheelchair. Interview with the resident on 8/3/17 at 9:54 AM revealed the wheelchair was in need of repair and s/he was unsure when or if the repairs were scheduled. The resident stated s/he was only able to propel the manual wheelchair short distances and not having use of the electric wheelchair limited his/her ability to get around the facility. Review of the medical record showed a physician order dated 6/13/17 for an electric wheelchair. Interview with the social service designee (SSD) on 8/3/17 at 9:34 AM revealed she was aware of the need to have the chair repaired. She had made calls and fixing the chair was not an option, but she stated there was a possibility of an electric wheelchair donation. The SSD verified this information was not documented in the resident's record and there was not an established timeframe for when an electric wheelchair might be available. Further, the SSD stated she had been in the position for 6 months and was still learning her role.	F 250	that resident #1 is not safe to use an electric wheelchair and documented. **Identification of Others** Orders for the last month were reviewed on 8/25/17 by the NHA to identify any resident who may have had orders for an electric wheelchair which have not been addressed. **Systemic Change** In-service education was provided to the social worker by the NHA on 8/25/17 regarding the requirement to document information regarding information/ progress regarding care or services needed. The social worker will review the previous business day's telephone orders 5 days per week to monitor for physician orders related to social service needs and document the progress of meeting those needs. She will document progress towards those on a tracking form. **Monitoring** The social worker/designee will report any concerns or patterns to the Quality Assessment Performance Improvement committee monthly for their review and resolution. These reports will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	

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F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 2 resident areas (North hallway, South hallway) were clean and in good repair. The findings were: The following concerns were identified during observations on 8/3/17 from 8:20 AM thorough 9 AM: 1. Concerns with heat radiator covers: a. The heat radiator cover in the bathroom of room #101 had the paint scraped off 36 inches across, exposing the metal underneath which created a surface that could not be effectively cleaned. b. The heat radiator cover in the bedroom of room #112 was observed to have collected dust along the entire 13 feet of the cover. c. The heat radiator cover in the bedroom of room #114 was observed to have collected dust along the entire 13 feet of the cover. In addition, the heat radiator cover in the bathroom was observed to have collected dust along the entire 34 inches of the cover. d. The heat radiator cover in the bedroom of room #115 was observed to have collected dust along the entire 13 feet of the cover. e. The heat radiator cover in the bedroom of room #117 was observed to have collected dust along the entire 13 feet of the cover. f. The heat radiator cover in the bedroom of room #118 was observed to have collected dust	F 253	**F 253** **Corrective Action** The Paint in room #101 was repaired on 8/3/17. The heat radiator covers in room #112, #114 and the bathroom, #115, #117,#118, #119, #126 and #135 were all cleaned and dust free on 8/3/17 by the Housekeeping supervisor. The gash in the wall in the bathroom of room #112 was repaired on 8/3/17. The yellowish and dusty strip in room #125 between the room and bathroom was cleaned on 8/8/17. The cracked tile in room #125 was and the caulk around the toilet replaced on 8/3/17 The North shower room door was repaired on 8/31/17. The inside of the door to room #137 was repaired on 8/25/17. The hole in at the head of the bed in room #138 was repaired on 8/3/17. The floor tile in the hallway at the fire doors outside of room #141 was replaced on 8/4/17 **Identification of Others**	8/31/17

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F 253	Continued From page 4 along the entire 13 feet of the cover. g. The heat radiator cover in the bedroom of room #119 was observed to have collected dust along the entire 13 feet of the cover. h. The heat radiator cover in the bedroom of room #126 was observed to have collected dust along the entire 13 feet of the cover. i. The heat radiator cover in the bedroom of room #135 was observed to have collected dust along the entire 13 feet of the cover. 2. Miscellaneous building concerns: a. The back wall in the bathroom of room #112 just above the baseboard had a gash that was 10 inches across and created a surface which could not be effectively cleaned. b. The bedroom floor in room #118 had dust and debris collected in all four corners. c. The floor in room #125 had a yellowish and dusty 32 inch strip between the bedroom and bathroom floors. The bedroom floor also had a 12 inch by 12 inch tile just inside of the front door that was cracked and created a surface which could not be effectively cleaned. In addition, the caulk around the toilet was pulling loose from the toilet base and was brown-stained. d. The inside of the north shower room door was damaged at the bottom right side corner with a 3 inch by 3 inch area mostly missing. e. The front door on the inside at the bottom left in room #137 was chipped in a jagged fashion from the floor to 32 inches up, and created a surface which could not be effectively cleaned. f. The wall at the head of the first bed in room #138 had a 3 inch diameter hole in the wall. g. The floor tiles in the hallway at the fire doors outside of room #141 had a 12 inch by 12 inch tile with 3 inches missing from the tile which was darkened and collecting dirt and debris.	F 253	The Housekeeping supervisor audited all resident rooms and bathrooms for dust on the heat radiator covers on 8/21/17 any identified areas were cleaned immediately. The Maintenance Director inspected all resident rooms, bathroom and common areas on 8/8/17 to identify any areas needing repair. Any identified concerns were corrected. **Systemic Change** In-service education was provided to the housekeeping staff by the Housekeeping Supervisor on 8/17/17 regarding the 4 Step and 7 Step cleaning processes for each room which includes dust mopping. In-service education was provided to the maintenance staff by the NHA on 8/23/17 regarding the expectation to ensure that cracked tiles are replaced; scrapes, gauges, and holes in walls and doors are repaired. The Maintenance Director/designee audits all rooms and common areas of the facility for needed repairs monthly to ensure that all walls, doors and floors are in good repair. Any identified areas are corrected. The Housekeeping Supervisor uses the Quality Control Inspection form to randomly spot check 3 resident rooms 3 times per week for dusty heat radiator covers in resident rooms and bathrooms and NHA will verify. Any identified concerns are corrected.	

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F 253	Continued From page 5 3. Interview and observation with the housekeeping supervisor on 8/3/17 at 9:35 AM confirmed the areas identified were in need of cleaning. 4. Interview and observation with the maintenance director on 8/3/17 at 9:50 AM confirmed the areas identified were in need of repair. He further confirmed the facility failed to have a plan with a timeframe to address those issues.	F 253	**Monitoring** The Housekeeping Supervisor reports any concerns or patterns related to dusty heat radiator covers to the Quality Assessment Performance Improvement Committee monthly for their review. These checks will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue. The Maintenance Director reports any concerns or patterns related to scrapes, gauges, holes in walls, doors or floors to the Quality Assessment Performance Improvement Committee monthly for their review. These checks will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a significant change MDS assessment was completed as required for 1 of 5 sample residents (#73) with significant changes in condition. The findings were: Review of the annual MDS assessment with an	F 274	**F 274** **Corrective Action** A significant change MDS assessment was completed for resident #73 on 8/9/17 by the RCMD per the RAI Guidelines. **Identification of Others** The RCMD/designee completed an audit on 8/24/17 of all current residents' 2 most recent completed ARDs to determine if a significant change assessment was warranted. Any assessments identified has having a change in the required areas have	8/31/17

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F 274	Continued From page 6 assessment reference date (ARD) of 2/18/17 showed resident #73 required limited assistance for personal hygiene and extensive assistance for dressing and bathing. All other ADLs were shown to require supervision only. A comparison review of the 5/18/17 quarterly MDS assessment showed the resident continued to have the same functional levels with the ADLs. However, the 7/23/17 quarterly MDS assessment showed the resident had a significant decline in ADL functional levels. The areas of bed mobility, transfer, walking, locomotion, eating, and toilet use were shown to require extensive assistance. Interview with MDS coordinator #1 on 8/3/17 at 9 AM confirmed the ADLs showed a decline and a significant change MDS assessment was needed and had not yet been started.	F 274	been resubmitted as a significant change MDS. **Systemic Change** In-service training was provided on 8/23/17 by District Director of Care Management to the RCMD, MDS Coordinator, DON and NHA regarding assessing for a significant change and how to complete a significant change assessment timely per RAI Guidelines. The RCMD audits 2 assessments per week for 30 days, then 2 every other week for 30 days, then 2 per month for 3 months to compare with prior ARD to ensure a significant change assessment is completed if warranted. The District Director of Care Management conducts a second check of these assessments. **Monitoring** The RCMD will review the results of her audit and report any concerns or patterns to the Quality Assessment Performance Improvement committee monthly for their review and resolution. These audits will continue as planned above unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification	F 278	**F 278** **Corrective Action** The assessments for resident #16, #18, #47,	9/3/17

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F 278	Continued From page 7 (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to ensure MDS assessments were accurately completed for 5 of 16 sample residents (#16, #18, #47, #56, #58) reviewed. The findings were: 1. Review of the 7/9/17 quarterly MDS assessment for resident #16 showed the resident was coded as having 3 unstageable pressure ulcers in section M0300F1. Further review of section M0610 showed the measurement of the largest pressure ulcer was left blank. 2. Review of the 5/16/17 quarterly MDS assessment for resident #18 showed the resident had diagnoses which included functional quadriplegia. Review of the medical record failed to show evidence to support this diagnosis. 3. Review of the 7/17/17 significant change MDS assessment for resident #47 showed section	F 278	#56 and #58 were modified on 8/3/17 by the RCMD/designee. **Identification of Others** The RCMD/designee conducted an audit on 8/25/17 of sections I, K and M for all current resident with an ARD in the last 60 days to validate accuracy of each sections. Modifications were completed for any assessments with inaccuracies. **Systemic Change** In-service education was provided to the RCMD, MDS Coordinator, DON and NHA by the District Director of Care Management on 8/23/17regarding following the RAI Guidelines to ensure accurate coding in each of these sections. RCMD/designee completed an audit of 2 assessments per week for 30 days, then 2 assessments every other week for 30 days and then 2 assessments per month for 3 months to ensure accurate coding of sections I, K and M. The District Director of Care Management conducts a second check of these assessments. **Monitoring** The RCMD will review these audits	

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F 278	Continued From page 8 K0200 was left blank for height. 4. Review of the 5/19/17 quarterly MDS assessment for resident #56 showed inaccuracies in the following areas: a. Review of section I showed the resident had diagnoses which included septicemia and pneumonitis due to inhalation of food and vomit. Review of progress notes showed the resident was hospitalized related to these diagnoses more than 60 days prior to the 5/19/17 assessment. b. Review of section K0200 was left blank for weight. 5. Review of the 5/15/17 quarterly MDS assessment for resident #58 showed the resident had one or more unhealed pressure ulcer(s) at stage one or higher. However, the next section (M0300) used to show the number of unhealed pressure ulcers at each stage was not completed accurately, it showed the resident had no stageable pressure ulcers. 6. Interview on 8/3/17 at 11:35 AM with MDS coordinators #1 and #2 verified the inaccuracies on these MDS assessments including the diagnoses which were not accurate at the time the assessments were completed. 7. Review of the "CMS RAI version 3.0 manual, October 2016" showed under section I "...Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period..."	F 278	monthly and report any patterns or concerns to the Quality Assessment Performance Improvement committee monthly for their review and resolution. These audits will continue as planned above unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 280	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 280	**F 280**	8/31/17

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F 280 SS=D	Continued From page 9 PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and	F 280	**Corrective Action** The care plans for resident #47 and #56 care plans were reviewed and updated on 8/4/17 by the RCMD to accurately reflect the resident's current preferences and needs. **Identification of Others** RCMD/designee completed an audit of all current residents to ensure current code status, current psychotropic medication orders and current transfer needs are accurately reflected in the care plan. Any identified changes were updated. **Systemic Change** In-service education was provided to the RCMD, MDS Coordinator, Social Worker, DON and NHA on 8/23/17 by the District Director of Care Management regarding following the RAI Guidelines to ensure accuracy of care planning code status, psychotropic medication and transfer needs. RCMD/designee audits 2 residents per week for 30days, then 3 residents every other week for 30 days than 2 residents per month for 3 months to ensure accurate care planning of code status, psychotropic medications and transfer needs. The District Director of Care Management conducts a second check of these assessments.	

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F 280	Continued From page 10 cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 280	**Monitoring** The RCMD will review these audits monthly and report any patterns or concerns to the Quality Assessment Performance Improvement committee monthly for their review and resolution. These audits will continue as planned above unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	

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F 280	Continued From page 11 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure care plans were revised for 2 of 16 sample residents (#47, #56) reviewed. The findings were: 1. Review of the care plan for resident #47 showed the following concerns: a. Review of the care plan last revised on 7/16/17 showed the resident had chosen to be a DNR (do not resuscitate). Review of the medical record showed the resident had changed this directive on 7/28/17 to "CPR, full treatment." b. Review of the care plan last revised on 6/13/17 showed the resident received Zoloft (an antidepressant). Review of the July 2017 MAR (medication administration record) showed the medication was discontinued on 7/10/17. 2. Review of the care plan for resident #56 last revised on 5/1/17 showed the resident transferred with a "Sit to Stand" mechanical lift with the extensive assistance of 2 staff members. Observation on 8/1/17 at 10:05 AM showed CNA #1 entered the resident's room to perform incontinence care, however, a "Sit to Stand" lift was not present in the room at that time. Interview on 8/1/17 at 6:10 PM with CNA #2 revealed the resident required the assistance of one staff member and used the pivot method for transfers. 3. Interview on 8/3/17 at 11:35 AM with MDS coordinator #2 verified the identified care plan areas needed to be revised.	F 280		
F 282	483.21(b)(3)(ii) SERVICES BY QUALIFIED	F 282	F 282 **Corrective Action** Resident #40 fall intervention for a floor mat next to the bed was reassessed by the IDT on 8/10/17 and was determined to be a safety hazard and was removed from the room. The care plan for resident #40 was updated on 8/10/17.	8/31/17

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282 SS=D	Continued From page 12 PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was followed for 1 of 16 sample residents (#40). The findings were: Review of the 5/11/17 quarterly MDS assessment showed resident #40 had diagnoses which included a history of falls. Further review showed the resident required the extensive assist of one person with transfers. Review of the progress notes showed the resident had falls without injury on 5/3/17, 6/3/17, and 7/4/17. Review of the 6/18/16 care plan related to risk for fall or injury showed interventions included a floor mat in place at bedside. Observation on 8/1/17 at 8:55 AM showed the resident was lying in bed without a fall mat on the floor beside the bed at that time. Observation on 8/2/17 at 12:25 PM showed the resident was lying in bed and no fall mat was on the floor beside the bed at that time. Interview with MDS coordinator #2 on 8/3/17 at 9:10 AM verified the expectation was for the care plan to be followed which would include the fall mat being in place while the resident was in bed.	F 282	**Identification of Others** The RCMD/designee completed an audit of all resident with an intervention to have a fall mat next to their bed are in place and the care givers are following the care plan. **Systemic Change** In-service education was provided to the IDT and nursing staff on 8/23/17 by District Director of Care Management regarding where to find fall mat interventions and expectations of following the care plan. The RCMD/designee audits 2 resident's care plans who are to have a fall matt next to their bed 1 time per week for 30 days, then 1 time every other week and then 1 time per month for 3 months. The District Director of Care Management conducts a second check of these assessments. for appropriate interventions **Monitoring** The RCMD will review these audits monthly and report any patterns or concerns to the Quality Assessment Performance Improvement committee monthly for their review and resolution. These audits will continue as planned above unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS	F 328	**F 328** **Corrective Action**	8/31/17

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F 328	Continued From page 13 (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care	F 328	Resident # 16 was discharged on 8/22/17. Resident # 56 was monitored for oxygen saturation for 3 days to determine if continuous oxygen was needed. On 8/5/17 the facility completed the monitoring of her oxygen and it was determined that she will continue with an order for PRN oxygen. Oxygen equipment is supplied if necessary. **Identification of Others** An audit was conducted of all residents to determine if oxygen is needed and the frequency on 8/26/17 by the Unit Manager. The orders were corrected to reflect requirements for need. Oxygen equipment is supplied when necessary. **Systemic Change** In-service education was provided to the nursing staff on 8/31/17 by the DON/designee regarding the requirement to document symptoms/change of condition requiring the use of PRN oxygen. The DON/designee audits residents with PRN oxygen weekly to ensure correct usage of oxygen. Any concerns will be addressed by the DON/designee. The IDT reviews the changes of condition 5 days per week to identify any resident	

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F 328	Continued From page 14 and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and professional standard review, the facility failed to ensure oxygen was delivered as ordered for 2 of 9 sample residents (#16, #56) who required oxygen. The findings were: 1. Observation on 7/31/17 at 3:33 PM showed resident #16 was seated in his/her room in a wheelchair with an oxygen concentrator running, however, the nasal cannula was on the floor. The oxygen saturation level obtained by CNA #3 at 3:46 PM was measured at 98%. Review of the July 2017 TAR (treatment administration record) showed "Oxygen: May apply 2 liters of oxygen via nasal cannula as needed if resident displays signs/symptoms of respiratory distress-shortness of breath, difficulty breathing, decreased saturation levels, etc." was ordered with a start date of 5/5/17. The following concerns were identified:	F 328	with a change in oxygen need and reviews the documentation supporting the initiation and continuation of oxygen use. **Monitoring** The DON reports any concerns or patterns regarding proper use of oxygen and documentation to the Quality Assessment Performance Improvement Committee monthly for their review. These checks will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	

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F 328	Continued From page 15 a. On 8/1/17 at 7:55 AM the resident was observed in the dining room with oxygen and continued to use the oxygen until 10:45 AM when s/he left the facility for an appointment. On 8/2/17 at 11:38 AM and again at 4 PM the resident was observed with oxygen in use, Review of the progress notes showed no indication for oxygen supplementation. b. Review of the July 2017 TAR and MAR (medication administration record) showed no documentation for the use of the oxygen. Review of the July 2017 progress notes showed no indication for oxygen supplementation. 2. Observation on 8/1/17 at 8:55 AM showed resident #56 was in the activity room in his/her wheelchair visiting with a friend with oxygen in use. Observation on 8/2/17 at 11:38 AM and again at 4 PM showed the resident was in the dining room with oxygen in use. Review of the July 2017 TAR showed "Oxygen: May apply 2 liters of oxygen via nasal cannula as needed if resident displays signs/symptoms of respiratory distress-shortness of breath, difficulty breathing, decreased saturation levels, etc." was ordered with a start date of 11/25/16. The following concerns were identified: a. Interview with the resident on 8/1/17 at 9:15 AM revealed s/he had to wear the oxygen all the time and "didn't like it." Review of the 5/19/17 quarterly MDS assessment showed the resident had a BIMS score of 11/15 (moderate cognitive impairment). b. Review of the July 2017 TAR and MAR showed no documentation for the use of the oxygen. Review of progress notes from 5/1/17 through 8/2/17 showed no indication for oxygen supplementation.	F 328		

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F 328	Continued From page 16 3. Interview on 8/3/17 at 9:30 AM with the district nurse confirmed the oxygen ordered for resident #16 and #56 were for as needed use only. 4. Interview on 8/2/17 at 3:55 PM with the DON revealed it was her expectation residents be reassessed for the need for supplemental oxygen and be titrated off, if indicated. According to Smith, Duell, Martin: Clinical Nursing Skills, Seventh Edition, 2008, page 959 under "Oxygen Administration" "...Check physician's orders for mode of oxygen delivery and prescribed oxygen liter flow...Evaluate SPO2 (blood oxygen saturation level) 30 minutes after any change in oxygen flow rate." According to Lippencott Nursing Procedures, Seventh Edition, 2015, page 573 under "Oxygen Administration"; "...Verify the practitioner's order for the oxygen therapy because oxygen is considered a medication or therapy and should be prescribed."	F 328		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431	**F 431** **Corrective Action** The family of the resident who has medication delivered from an outside pharmacy was spoken to on 8/23/17 by the nurse and the family agreed to get the medications from the facility contracted pharmacy. The Division Director of Pharmacy spoke to the facility back-up pharmacy manager regarding the requirement to	8/31/17

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F 431	Continued From page 17 biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	have expiration dates on all medications delivered to the facility on 8/21/17. The back-up pharmacy agreed to place the expiration date on the back side of the medication card. **Identification of Others** All medications provided by pharmacies other then the facility contracted pharmacy were audited by 8/23/17 on ADON for expiration dates. Any identified concerns were addressed. **Systemic Change** Education was provided to the nursing staff by 8/31/17 by SDC regarding checking all medications that are delivered to the facility for an expiration date. If a medication does not have an expiration date the delivery is to be refused and sent back to the pharmacy of origin. The Director of Nursing/designee audits medications delivered to the facility by pharmacies other then the contracted pharmacy to ensure that all medication have an expiration date weekly. Any identified concerns are corrected. **Monitoring** The DON reports any concerns or patterns regarding expiration dates on medications to the Quality Assessment Performance Improvement Committee monthly for their	

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F 431	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the Wyoming Pharmacy Act Rules and Regulations, the facility failed to ensure medication labels included an expiration date in 2 of 6 medication storage areas (northeast and northwest medication carts). The findings were: Observation of the northeast medication cart on 8/3/17 at 10:10 AM showed three bottles of medications (Imitrex 50mg-2 tabs, Lasix 80mg-3 tabs, Zofran 4mg-4 tabs) from a local pharmacy were labeled without expiration dates. Interview with LPN #1 verified these medications were available for use and did not have an expiration date. Observation of the northwest medication cart on 8/3/17 at 10:22 AM showed five bottles of medications (allopurinol 100mg-1 tab, Tessalon per 100mg-9 tabs, levothyroxine 112 mcg-13 tabs, lisinopril 20mg-11tabs, tamsulosin hcl 0.4mg-14 tabs) from a local pharmacy were labeled without expiration dates. Interview with RN #1 verified that medications were available for use and did not have an expiration date. According to the Wyoming Pharmacy Act Rules and Regulations, Chapter 2 Section 11 (iv), "labeling of prescription drug containers shall be labeled with manufacturer's expiration date. If prepackaged or repackaged by the pharmacy, the expiration date shall be the lesser of the manufacturer's expiration date or twelve months from the date of prepackaging or repackaging."	F 431	review. These checks will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465	**F 465** **Corrective Action** On 8/2/17 the ice machine was shut	8/31/17

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F 465	Continued From page 19 E ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a random staff-accessed room (the ice room on the north hallway) was maintained in a sanitary manner. The findings were: 1. Observation on 8/2/17 at 8:40 AM showed the following issues with the north hallway ice room: a. The wall to the left of the sink had a small chipped out area, and multiple missing tiles. The damage created a surface which could not be effectively cleaned. Tiles were also missing to the right of the sink. b. The right side of the floor by the inner area of the front door had a 3 inch area missing from the floor. The area was darkened with dirt and debris. c. Various items were stored in the bath tub at the back of the room which was dirty with dust and debris. d. Over the surface of the ceiling the paint was chipped and peeling and created a surface which could not be effectively cleaned. e. The utility sink was dirty with darkened	F 465	down and drained, the water pitchers were removed, washed and stored in a different area and the lock changed on the door so that the room was no longer accessible to staff other then the maintenance department. The facility has hired an outside contractor to gut the room to the studs, including replacing the flooring to ensure all cleanable surfaces and reinstall only the ice machine. **Identification of Others** There are no other rooms similar to this in the facility. **Systemic Change** The facility has hired an outside contractor to gut the room to the studs, including replacing the flooring to ensure all cleanable surfaces and reinstall only the ice machine and cleanable shelving for the water pitchers. This room has remained locked and will remain locked until the work is complete with the exception of the people working in the room. **Monitoring** The Maintenance Director will monitor the condition of the ice machine room and report any concerns to the Quality Assessment Performance Improvement Committee monthly for their review and direction. These inspections will continue for 3 months unless the Committee deems it prudent to continue.	

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F 465	Continued From page 20 stains. f. Resident water pitchers were stored in the unclean ice room on shelves against the left wall and were available for use. 2. Observation and interview with the maintenance director on 8/3/17 at 1:10 PM confirmed the issues identified with the north hall ice room. He further confirmed the facility failed to have a plan with a timeframe to repair and clean the issues identified.	F 465		
F 507 SS=D	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to file laboratory reports in the medical record for 1 of 16 sample residents (#47) reviewed. The findings were: Review of a physician order dated 6/19/17 for resident #47 showed a CBC (complete blood count), CMP (comprehensive metabolic panel), TSH (thyroid stimulating hormone) and T4 (a test for thyroid function) was ordered for 6/26/17. Review of a physician's progress note dated 7/10/17 revealed the laboratory results had been reviewed, however a copy of the report was not in the medical record at the time of the survey (37 days). Interview on 8/3/17 at 1:45 PM with the unit	F 507	**F 507** **Corrective Action** A copy of the Lab results for resident #47 was placed in the medical record on 8/21/17. **Identification of Others** The DON/designee audited all of the current resident charts for lab results for the last 30 days to ensure that all lab results are in the record. Any identified concerns were corrected. **Systemic Change** The DON/designee audits the lab results weekly days per week comparing the orders, results to what is in the resident's chart to ensure all lab results are in the medical record.	8/31/17

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F 507	Continued From page 21 manager #1 verified the laboratory report had been electronically accessed and printed from the testing laboratory upon request from the surveyor.	F 507	In-service education was provided to the licensed nursing staff and completed on 8/31/17 by DON/designee regarding the requirement to have the lab results in the resident's record. **Monitoring** The DON reports any concerns or patterns regarding the audit of the lab results in the record to the Quality Assessment Performance Improvement Committee monthly for their review. These checks will continue for 3 months unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	