STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 2/12/18 through 2/15/18. The following common abbreviations are used throughout this document: cm- centimeters CNA- Certified Nurse Aide LPN- Licensed Practical Nurse MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and in place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages	F 576		3/12/18

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

Electronically Signed | 03/07/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576	Continued From page 1 and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and post office employee interview, the facility failed to provide residents the right to send and receive mail on Saturday. The facility census was 35. The findings were: 1. Interview with 9 residents on 2/13/18 at 9:42 AM revealed they received mail on weekdays only, and they did not receive mail on Saturdays. 2. Interview on 2/13/18 at 12:42 PM with the office manager revealed she retrieved mail from the facility's post office box at the post office Monday through Friday. She further stated the mail was delivered only to rural areas on the weekends, and the post office was only open until 10:30 AM on Saturday. She further stated she didn't pick up the mail on Saturday because the business office was closed and no one was	F 576	F576 The Facility will ensure resident's right to send and receive mail on Saturday. This will be accomplished by: 1. The DON had instructed the designated activity personnel on Saturday will pick the mail up on Saturday morning and deliver the mail to the designated residents. 2. The DON met with the activity personnel on Thursday, March 8, 2018 and instructed the activity personnel they would be in charge of picking up and delivering resident's mail on Saturday morning. 3. If for any reason the activity personnel	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576	Continued From page 2 available to get the mail. She further stated she picked up Saturday's mail with Monday's mail, and there typically wasn't much mail for those two days. 3. Interview on 2/15/18 at 10:30 AM with the CNA manager revealed the post office delivered packages and boxes on Saturday, and mail was delivered to rural areas only on Saturdays. 4. Interview on 2/20/18 at 10:42 AM employee #1 of the local post office revealed the post office was open on Saturdays from 9 AM to 11 AM. She further revealed that all town residents who lived in town had a post office box and mail was delivered only to rural areas. The employee also stated the nursing home's mail was placed in their post office box on Saturday, and most of the time there was a decent amount of mail.	F 576	are unable to pick the mail up Saturday, the nursing staff is to be notified and will notify the DON someone will need to pick up and deliver the mail on Saturday or designate a staff member to pick up and deliver the mail on Saturday. 4. The activity director met her staff on March 8, 2018 and the DON will meet the nursing staff on March 12, 2018 to discuss mail procedure on Saturday. 5. A quality improvement monitoring tool will be implemented by the DON to ensure residents are sending and receiving their mail on Saturday. The monitor will by completed monthly, and reported quarterly at the QAPI meeting. Appropriate follow-up actions will be initiated by the QI committee.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, review of facility policy, and review of the CMS Resident Assessment Instrument (RAI) version 3.0 manual, the facility failed to ensure MDS assessments were accurately completed for 1 of 12 sample residents (#133). The findings were: 1. Medical record review showed resident #133 was admitted from the hospital on 1/30/18 with	F 641	F641 The facility will ensure MDS assessments are accurate. This will be accomplished by: 1. Resident #133 MDS was modified and submitted reflecting the current level of care resident #133 is receiving. 2. The DON instructed the MDS	3/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 3 diagnoses that included diabetic foot ulcer and vascular surgery. Interview with the resident on 2/13/18 at 10:25 AM revealed s/he developed a pressure ulcer on his/her buttock while in the hospital. Observation on 2/14/18 at 1:35 PM showed resident had a 1.1 cm area of healing skin on the coccyx covered with a dressing dated 2/12/18. Review of the nursing admission evaluation and interim care plan showed a diagram of the human body with the coccyx area circled and "1 cm black escar (sic)" documented. Review of a nurse's note dated 1/30/18 at 5:30 PM showed, "Resident also has 1 cm escar (sic) to coccyx. Allevyn dressing applied for protection." Review of a nurse's note dated 2/12/18 at 8:30 PM showed, "Resident has a sore at top of butt crack that [s/he] reports [s/he] got while in the hospital. This RN placed Alevyn on site." The following concerns were identified: a. Interview on 2/14/18 at 3 PM with the MDS coordinator confirmed she considered the wound a pressure ulcer. b. Review of the admission MDS assessment revealed Section M Skin Conditions lacked documentation related to the pressure ulcer. The MDS was signed as completed on 2/8/18. Interview with MDS coordinator on 2/15/19 at 8:45 AM revealed the MDS was complete. c. Review of the facility policy titled "Pressure Ulcer Prevention" with a revision date of 12/17 stated, "Nursing staff upon admission is to... identify the presence of pressure ulcers." d. Review of the RAI 3.0 User's Manual dated October 2017 showed under Section M "...Steps for Assessments...1. Review the medical record...including skin care flow sheets, and nurses' notes. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and	F 641	coordinator, any MDS assessment found to not reflect the resident's current level of care is to modified immediately and submitted. The MDD coordinator was notified on March 12, 2018 to modify the assessment for resident #133 and submit it immediately. Other MDS assessments for residents with a pressure ulcer were reviewed, no errors were found. 3. The DON will review residents admitted, the weekly skin report provided by the treatment nurse and weekly skin checks, for skin breakdown such as pressure ulcers and will assess the completed assessment reflects the current level of care the resident is receiving. 4. This will be accomplished by the DON reviewing 4 random assessments monthly. The assessments are to include, admission, quarterly,SCOS and annual assessment. 5. A Quality improvement monitoring tool will implemented by the DON to ensure accuracy of the MDS assessments. This monitor will be completed monthly, and reported quarterly at the QAPI meeting. Appropriate follow-up actions will be initiated by the QI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 observations of the resident..." Continued review showed ..."Pressure ulcers that eschar (tan, black or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized...should be classified as unstageable..." Further review showed..."For each pressure ulcer, determine if the pressure ulcer was present at the time of admission...and not acquired while the resident was in the care of the nursing home..."	F 641		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review and policy review, the facility failed to provide necessary services and treatment to promote healing of a pressure ulcer for 1 of 1 sample resident (#133) with a pressure ulcer. The findings were: 1. Medical record review showed resident #133 was admitted from the hospital on 1/30/18 with	F 686	F86 The facility will ensure residents will be provided necessary services and treatments to promote healing of pressure ulcer. This will be accomplished by: 1. Resident #133 physician was notified on 02/20/2018 of the presence of a pressure ulcer and an order received for	3/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 5 diagnoses that included diabetic foot ulcer and vascular surgery. Interview with the resident on 2/13/18 at 10:25 AM revealed s/he had developed a pressure ulcer on his/her buttock while in the hospital. Further interview revealed the facility staff placed a dressing on it. Observation on 2/14/18 at 1:35 PM showed the resident had a 1.1 cm area of healing skin on the coccyx covered with a dressing dated 2/12/18. Review of the nursing admission evaluation showed a diagram of the human body with the coccyx area circled and "1 cm black escar"(sic) documented. Review of a nurse's note dated 1/30/18 and timed 5:30 PM showed "resident also has 1 cm escar (sic) to coccyx. Alevyn dressing applied for protection." Review of a nurse's note dated 2/12/18 and timed 8:30 PM showed "resident has a sore at top of butt crack that [s/he] reports [s/he] got while in hospital. This RN placed Alevyn on site." Interview on 2/14/18 at 3 PM with the MDS coordinator confirmed she considered the wound a pressure ulcer. The following concerns were identified: a. There lacked evidence the physician was notified of the pressure ulcer. Review of the medical record showed no physician's orders or documentation related to the pressure ulcer. Interview on 2/14/18 at 3:00 PM with the MDS coordinator revealed the chart lacked physician documentation and orders related to the pressure ulcer. b. Medical record review on 2/14/18 failed to show consistent nursing documentation related to the wound or wound treatment. c. Review of the facility policy titled "Pressure Ulcer Prevention", last revised 12/17 showed "Nursing staff upon admission...is to identify the presence of pressure ulcers...Nursing staff will then develop and implement a comprehensive	F 686	treatment of the pressure ulcer. 2. Resident #133 comprehensive care plan was updated to reflect the resident had a pressure ulcer and intervention placed to promote healing of the pressure ulcer. 3. The DON will review residents medical records for pressure ulcers. This is to be accomplished by reviewing admission records, skin checks, and weekly skin report sheets provided by the treatment nurse weekly for signs of pressure ulcer. If there is documentation of a pressure ulcer or skin breakdown the DON will review the medical record the physician was notified and orders received for treatment of the pressure ulcer. 4. The DON will review resident's medical records for pressure ulcers and will review those residents identified with pressure ulcers comprehensive care plan to ensure appropriate interventions have been put into place to ensure the resident is receiving appropriate care to promote heeling of the pressure ulcer. 5. The DON will instruct nursing staff on March 12 ,2018 at the mandatory meeting physicians are to be notified of pressure ulcers and orders obtained of the appropriated treatment. 6.. A quality improvement monitoring tool will be implemented by the DON to ensure resident's are receiving the appropriate treatment of pressure ulcers, skin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 6 care plan that reflects each resident's needs....the nurse should monitor the impact of the interventions... the pressure ulcer must be reassessed at least weekly and the healing progress documented..."	F 686	breakdown consistent with standards of practice. This will be monitored monthly and reported quarterly at the QAPI meeting. Appropriate actions will be initiated by the QI committee .	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		3/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 7 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the medical record was complete for 1 of 12 sample residents (#18). The findings were:	F 842	F 842 The facility will ensure residents with akin tears and dressing are noted on the MAR with treatment and documentation of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 8 Observation on 2/12/18 at 5:17 PM revealed CNA #1 and LPN #1 transferred resident #18 from bed to wheelchair. At the time the LPN revealed the resident had a skin tear on his/her arm. Further observation at that time showed a white bandage on the resident's left arm, above the wrist. Observation on 2/13/18 at 9:56 AM revealed the resident still had a bandage on the left arm. Review of the medical record on 2/14/18 showed no documentation related to a skin tear on the resident's arm. During an interview on 2/14/18 at 2:49 PM the MDS coordinator confirmed there was no documentation related to a skin tear or the bandage on the resident's arm. She stated she spoke with the resident's nurse and looked under the bandage. She stated it was a small area that the resident picked/scratched.	F 842	wound in the resident's medical. This will be accomplished by: 1. Resident #18 medical record was updated to reflect the skin tear and treatment to be provided to the wound. All other resident's were assessed for wounds such as skin tears, 1 resident identified with a skin tear and medical record updated to reflect the skin tear and treatment. 2. The DON will instruct nursing staff at the mandatory nurses meeting on March 12, 2018 any resident sustaining a skin tear will have the proper documentation placed in the resident's medical record and treatment placed on the MAR in regards to the wound. The bandage will be dated and initials placed on the dressing to notify nursing staff when the dressing was last changed. 4. The DON will monitor for proper documentation and dressing placed on the MAR by reviewing the weekly skin sheet provided by the treatment nurse, skin checks and incident reports stating a wound was sustained. 5. A quality improvement monitoring tool will be implemented by the DON to ensure the appropriate documentation was placed on the resident's medical record. This monitor will be completed monthly and reported quarterly at the QAPI meeting. Appropriate follow-up actions will be initiated by QI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 9	F 865		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the facility's written QAPI plan and staff interview, the facility failed to ensure the plan contained all the required elements. The findings were: Review of the facility's plan titled "QAPI Policy" showed it did not describe the process for identifying and correcting quality deficiencies. The policy listed the members of the QAPI oversight team and listed the frequency of meetings. Specifically, the plan lacked the following: a. Tracking and measuring performance. b. Establishing goals and thresholds for performance measurement. c. Identifying and prioritizing quality deficiencies.	F 865	F865 F865: QAPI In response to deficiency F865, in which the facility was noted as having failed to describe the process for identifying and correcting quality deficiencies. On 03/10/18 The QAPI policy was reviewed and updated to insure the plan contained all the required elements specifically to show the process for identifying and correcting quality deficiencies. Our Oversight QA committee meeting will be held following our State survey and every quarter following. We will address all identified quality deficiencies immediately The Oversight committee will have	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	02/15/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 10 d. Analyzing underlying causes of systemic quality deficiencies. e. Developing and implementing corrective action or performance improvement activities. f. Monitoring the effectiveness of corrective action, and revising as needed. During an interview on 2/15/18 at 8:07 AM the QAPI coordinator stated the facility was in the process of revising the written QAPI plan/policy and confirmed the current policy/plan did not contain all the required elements.	F 865	responsibility for reviewing suggestions, and input from residents, staff, and family members as well. Data will come from but is not limited to the following areas: our annual state survey, CASPER report, drug regimen review summery, Infection control program, safety/falls/restorative committee, resident and family satisfaction (Care Plan meetings). The Oversight committee will: 1.identify and prioritize quality deficiencies and determine which performance improvement projects will be initiated first 2. Track and measure performance 3.Establish goals and thresholds for performance measurement 4. Analyze underlying causes of systemic quality deficiencies 5. Develop and implement corrective action 6. Monitor the effectiveness of corrective action and revise as needed, When an issue or problem is identified the Oversight committee will decide how to address the issue or problem and assign one or more team members to track, measure quality deficiencies, identify systemic issues and root causes. These corrections may include an easy decision, corrective action plan, rapid improvement cycle or may require complete system oversight and change. The committee will monitor progress, provide input, and ensure the individuals involved in QAPI have the resources they need.	