STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/26/18 to 3/1/18. Also reviewed in the course of the survey were complaint intakes WY00002419, WY00002431, WY00002549 and WY00002574. The following common abbreviations are used throughout this document: CMS- Centers for Medicare and Medicaid Services CNO- Chief Nursing Officer LPN- Licensed Practical Nurse MDS- Minimum Data Set PA- Physician Assistant RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents were safe to self-administer medications for 1 of 11 residents (#4) observed during medication pass. The findings were: Observation on 2/27/18 at 11:29 AM showed resident #4 self-administered prednisone acetate eye drops with one drop to each eye after LPN #1	F 554	F554 - This requirement will be met as evidenced by: A.) Resident Self Administration of Medications Policy will be updated. All nursing staff will read and sign policy. Assessment for self-administration of medications was completed for resident #4, and a review of all other residents who	4/30/18

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

Electronically Signed | 03/26/2018

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F 554	Continued From page 1 gave the bottle to the resident. Medical record review showed the facility failed to document an assessment to determine if the resident was safe to self-administer medication. Interview with the CNO on 2/28/18 at 1:46 PM confirmed that the resident self-administered some of his/her medications. She further confirmed the facility failed to assess the resident to ensure s/he was safe to self-administer his/her medications.	F 554	self administer was performed. An assessment for each will be completed and reviewed by the interdisciplinary team by April 30, 2018. B.) A monitoring tool will be developed in order to assess and document the safety of each resident who self administers medications. C. Monitoring tool will be completed monthly and reported on quarterly at QAPI meeting	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure quarterly assessment MDS assessments were completed every three months for 1 of 12 sample residents (#13). The findings were: Review of the MDS assessments for resident #13 showed a quarterly assessment with an assessment reference date (ARD) of 7/3/17. The next MDS assessment was a quarterly assessment dated 12/4/17 (5 months after the previous quarterly MDS assessment). During an interview on 2/27/18 at 3:59 PM the CNO confirmed the quarterly MDS assessment was late and should have been done in October. She	F 638	F638 - This requirement will be met as evidenced by: A.) A review of all MDS's will be done to ensure no other assessments were missed. All Interdisciplinary team members will be trained in the process of timing for MDS's. MDS for resident #13 will be completed and submitted to CMS for review. The most recent MDS done on resident #13 was a quarterly assessment on 3/6/18. B.) Monitoring tool will be developed in order to monitor that all MDS	4/30/18

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F 638	Continued From page 2 stated she started in August and the assessment must have slipped through the crack.	F 638	assessments are completed on a timely basis. C.)Monitoring tool will be completed monthly and reported on quarterly at QAPI meeting	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640		4/30/18

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F 640	Continued From page 3 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of CMS MDS submission data, the facility failed to ensure MDS assessments were transmitted for 2 of 2 non-sample residents (#125, #126). The findings were: 1. Review of CMS MDS submission data showed two facility residents did not have current MDS assessments. Resident #125 had one assessment listed: a 6/5/17 annual MDS assessment. Resident #126 had one assessment listed: a 6/5/17 admission MDS assessment. 2. Review of the medical records showed the following: a. Resident #125 had two quarterly MDS assessments dated 9/6/17 and 12/5/17. b. Resident #126 had two quarterly MDS assessments dated 9/6/17 and 12/5/17.	F 640	F640 - This requirement will be met as evidenced by: A.) A review of all resident MDS submissions to ensure completeness will be done by April 30, 2018. MDS's for residents #125 and #126 for the dates of 9/6/17 and 12/5/17 will be completed and submitted for review by CMS. B.) Monitoring tool will be developed in order to ensure that all MDS assessments are submitted and accepted. C.) Monitoring tool will be completed monthly and reported on quarterly at QAPI meeting to ensure MDS assessments are submitted and accepted as required.	

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F 640	Continued From page 4 3. During an interview on 3/1/18 at 11:32 AM the social services director, who transmits the MDS assessments, stated she was not able to provide evidence the quarterly MDS assessments dated 9/6/17 and 12/5/17 for residents #125 and #126 had been transmitted to CMS. She stated she was unable to locate "submission folders" on her computer for the MDS assessments.	F 640		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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 657		4/30/18

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F 657	Continued From page 5 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff and resident interview, the facility failed to ensure the care plan was revised as needed for 3 of 12 sample residents (#1, #12, #23). The findings were: 1. During an interview on 2/27/18 at 9:08 AM resident #1 stated s/he currently had a urinary tract infection (UTI) and frequently had UTIs. Review of a physician's note dated 2/27/18 showed the resident had frequent UTIs, "...nearly monthly for past 4-5 months." However, review of the care plan, last reviewed 1/10/18, showed frequent UTIs was not addressed. 2. Review of the care plan for resident #12, last reviewed 2/21/18, showed "diet as ordered" and "...will maintain 171# or less through next review." However, review of the 2/20/18 quarterly MDS assessment showed the resident weighed 150#. In addition, review of a 2/14/18 registered dietitian (RD) note showed the resident received Ensure as a supplement. A 1/10/18 physician note documented the resident said s/he wasn't eating, but received a supplement. Observation on 2/28/18 at 12:46 PM showed the resident was drinking a supplement in the dining room. Review of physician orders showed on 1/20/18 the physician ordered "encourage Ensure at meals." The resident's care plan was not updated to reflect the resident's current weight or the supplement. 3. During an interview on 2/28/18 at 10:52 AM the RD stated resident #23 had weight loss and received Carnation Instant Breakfast once per	F 657	F657 - This requirement will be met as evidenced by: A.) All resident care plans will be updated by no later than April 30, 2018. Care plans will then be updated on every resident at same time their MDS assessment is due as well as when necessary changes occur in resident condition or level of care. The Care Plan for resident s #1, #12, and #23 will be reviewed and revised to show current plan of care. B.) Monitoring tool will be developed in order to ensure that all care plans are being updated as they come due. C.) Monitoring tool will be completed monthly and reported on quarterly at QAPI meeting.	

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F 657	Continued From page 6 day, a Breeze drink two times per day, and a nutritional shake two times per day. A note by the RD dated 1/17/18 showed the resident received supplements multiple times daily. Observation on 2/28/18 at 5:45 PM in the dining room showed the resident had a Breeze drink and a nutritional shake. Observation in the kitchen on 2/28/18 at 4:02 PM showed a list for "specialty drinks." Resident #23 was listed for Mighty Shakes for breakfast, lunch, dinner and Breeze drink for breakfast, lunch and dinner. In addition, it was posted that the resident received Carnation Instant Breakfast for breakfast. However, review of the care plan, last reviewed 1/23/18, showed only the Breeze supplement was included. The care plan did not include the nutritional shake or the Carnation Instant Breakfast. 4. During an interview on 3/1/18 at 11:30 AM the CNO confirmed the care plans for residents #1, #12, and #23 were not updated regarding UTIs and nutritional interventions.	F 657		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident	F 710		4/30/18

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F 710	Continued From page 7 is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on former employee interview, observation, medical record review, and staff interview, the facility failed to ensure the resident's physician wrote orders for medications for 1 of 12 sample residents (#21). The findings were: 1. Review of physician progress notes showed on 4/6/17 resident #21 established care with a new physician. The progress note read "...all other treatments and meds will continue as before with no changes." However, there lacked evidence of an physician order to continue medications as before. The following concerns were identified: a. Interview 3/1/18 at 8:45 AM with former employee PA #1 revealed she became aware on 2/28/18 that medication, specifically warfarin, was still being filled under her name for this resident, and she was no longer the provider for this resident. The PA stated she left in March 2017. b. Observation of medications for resident #21 with RN #1 on 3/1/18 at 9:42 AM showed the label on the Meloxicam and Coumadin had PA #1 as the current practitioner for the medication orders. c. Review of the "Medications Report" provided by the facility on 3/1/18 at 9:27 AM showed PA #1 was still listed as the ordering practitioner for 10 routine and as needed (PRN) medications for resident #21. d. Interview with the CNO on 3/1/18 at 9:27 AM revealed the physician did not write new	F 710	F710 - This requirement will be met as evidenced by: A.) All primary providers will review assigned residents medications and approve continued administration. Medications will be ordered under correct provider in EMR and a prescribing pharmacy by no later than April 30, 2018. During interdisciplinary team meetings, provider changes will be reviewed and addressed. All primary provider orders for resident #21 will be revised to reflect the current provider. B.) Monitoring tool will be developed in order to ensure the correct provider wrote the orders for medications given for each resident for current and any future orders. C.) Monitoring tool will be completed monthly and reported on quarterly at QAPI meeting, to ensure all provider orders are up to date and correct.	

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F 710	Continued From page 8 orders when he took over care of the resident. She stated some medications were still under the previous provider's name.	F 710		