STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535038	A. BUILDING _____ B. WING _____	04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 4/9/18 to 4/12/18. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator PTA: Physical Therapy Aide RA: Resident Advocate Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		5/24/18

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

Electronically Signed | 05/04/2018

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure the dignity of 2 of 12 sample residents (#12, #43). The findings were: 1. Observation on 4/10/18 at 10:31 AM during an interview with resident #12 showed an activity aide knocked on the door and entered the room before the resident could respond. Interview with the resident at that time revealed this happened all the time, and it made him/her feel like s/he did not have any privacy. Review of the 1/22/18	F 550	Director of nursing to provide education for all staff on 5/10/18 regarding resident rights associated with knocking on doors. Staff will be educated to announce themselves and ask for permission to enter prior to entering resident rooms of those who are cognitively aware. Staff will be instructed to continue knocking on all resident doors regardless of ability to answer.	

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F 550	Continued From page 2 annual MDS assessment revealed the resident had a BIMS score of 15/15 (cognitively intact). 2. Observation on 4/10/18 at 11:56 AM during an interview with resident #43 showed a nurse knocked on the door and entered the room before the resident could respond. Review of the 1/1/18 quarterly MDS assessment showed the resident had a BIMS score of 15/15 (cognitively intact). 3. Group interview with 8 residents on 4/11/18 at 10:30 AM revealed none of the staff waited for a response before coming into redident rooms. 3. Interview with the NHA on 4/12/18 at 8:52 AM revealed it was her expectation staff knock on the door before entering, but not necessarily to wait for a response before coming into the room. In addition, she stated that was how staff were trained.	F 550	Topic to be discussed at resident council on 5/7/18 to educate residents on this process. Audit of all residents to be conducted on or before 5/24/18 by social service director or designee to assess resident preference prior to staff entry into the room. Care plans will be revised by the IDT team for those who request staff enter their room differently than the outlined procedure above. An audit will be conducted by Administrator or designee for four weeks to ensure compliance and as needed thereafter. Any concerns will be addressed immediately with staff and will be reported to the QA committee.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to provide assistance to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (#43) reviewed for accommodation of needs. The findings were:	F 558	A new, shorter height wheelchair was ordered for resident #43 on 4/16/18. Once delivered, the wheelchair will be fitted to resident #43, with assistance from rehabilitation staff, to ensure proper height of the chair.	5/24/18

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F 558	Continued From page 3 Review of the 1/1/18 quarterly MDS assessment showed resident #43 was admitted to the facility on 4/4/17 with diagnoses which included CVA (cerebral vascular accident) with hemiplegia or hemiparesis. Further, the resident had a BIMS score of 15/15 (cognitively intact), was understood and was able to understand, and required the extensive assistance of 1 staff member for locomotion in a wheelchair. The following concerns were identified: a. Interview with the resident on 4/10/18 at 11:41 AM revealed his/her wheelchair was too high off the floor because his/her feet barely touched the ground. As a result, s/he could not move the chair independently and had to wait for staff to come and help. Observation at that time showed the resident could touch the floor with his/her toes but was unable to place his/her feet on the floor in order to propel the wheelchair. b. Interview with the PTA on 4/12/18 at 3:06 PM revealed the height of the wheelchair had been addressed in the past and measurements had been made to obtain a shorter chair. However, the facility thought the chair would have to be custom-made because of the resident's size, and it was never followed up on. In addition, the facility was making an effort at that time to locate an appropriate-sized wheelchair and the resident had expressed excitement about the change.	F 558	An audit was conducted of all resident equipment by rehabilitation director or designee on or before 5/24/18 to ensure all resident needs are being met and that equipment provided is adequate and appropriate. Staff members were educated by director of nursing on 5/10/18 to remind them of procedure for residents needing specialized equipment for mobility. Any other residents needing specialized mobility equipment will be brought to the attention of the rehab director or designee for assessment. Once assessment is completed, rehab staff will communicate equipment needs to Administrator for approval and ordering. A monthly audit will be conducted by the Administrator or designee for a period of 90 days and as needed thereafter to ensure equipment is ordered and available for those who need it. Any concerns will be reported to the QA committee.	
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(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	F 577		5/11/18

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F 577	Continued From page 4 (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure survey results were posted in a place readily accessible to the residents. The census was 48. The findings were: Observation of the facility during the survey from 4/9/18 to 4/12/18 showed the survey binder was located in the reception area of the facility. The reception area was separated from the resident area by a door, which was kept closed. The binder was kept in the back of a receptacle mounted to the wall next to the business office. Brochures from the Ombudsman were located in front of the binder, which obscured the title of the binder.	F 577	The survey results binder was moved to a wall adjacent to the nurses station (a high traffic area of the facility) on 5/3/18. The binder is marked with signage to indicate "survey results" and can be viewed by all residents and visitors to the facility. All residents were given a notice of the binder's location in the facility. This notice was hand delivered to each resident's room on or before 5/11/18. The resident council was also made aware of this change in their meeting on 5/7/18 and was asked to discuss this change with other residents who may not be in attendance.	

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F 577	Continued From page 5 Group interview with 8 residents on 4/11/18 at 10:30 AM revealed they were unaware of where survey results were posted. Interview with the RA on 4/11/18 at 3:57 PM revealed she could not remember when the last time she had discussed the survey results with the resident council.	F 577	The Administrator or designee will audit to ensure the survey results are kept in a readily accessible area for the residents. This audit will take place monthly for a period of three months as needed thereafter. Any concerns will be addressed with the QA committee.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		5/17/18

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F 623	Continued From page 6	F 623		

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

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F 623	Continued From page 7 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued to 4 of 4 residents with hospital transfers (#7, #20, #29, #43). The findings were: 1. Review of the medical record showed resident #7 was transferred to the hospital on 1/26/18 for a fall which resulted in a pelvic fracture. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative.	F 623	Transfer forms were completed for residents #7, #20, #29, and #43 on 5/3/18. Audit of all residents transferred to acute care or to other facilities since 1/1/18 to ensure appropriate transfer documentation is completed in patient chart. Nursing to implement new process in which a transfer form will be completed and given to resident or resident	

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F 623	Continued From page 8 2. Review of the medical record showed resident #20 was transferred to the hospital for an acute change of condition on 1/12/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record showed resident #29 was transferred to the hospital for an acute change of condition on 1/27/18 and again on 2/4/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 4. Review of the medical record showed resident #43 was transferred to the hospital for a scheduled surgery on 3/20/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 5. Interview on 4/12/18 at 9 AM with the NHA revealed the facility did not issue a written notice of transfer for residents who were sent to the hospital. In addition the ombudsman was not informed of the transfer if the reason was for a scheduled surgery.	F 623	representative as soon as practicable prior to or following the transfer. Transfer form to include all required elements. In-service to be conducted with all nursing staff on 5/10/18 (education provided by Director of Nursing) to review new process and provide education regarding transfer requirements. DON or designee to audit for 90-days and as needed thereafter any resident chart after a resident is transferred to ensure compliance. Audit to ensure that each resident transferred had transfer notice sent to receiving facility and discussed with resident/resident representative within practicable time during/following transfer. Any concerns will be addressed with the QA committee.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(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	F 637		5/25/18

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F 637	Continued From page 9 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 complete a significant change MDS assessment for 1 of 3 (#29) sample residents with a significant change of condition. The findings were: Review of the 9/28/17 annual MDS assessment showed resident #29 required supervision only for bed mobility, transfers, locomotion on the unit, dressing, toilet use, and hygiene. A comparison review of the 12/25/17 quarterly MDS assessment showed the resident continued to have the same ADL functional levels. However, the 3/23/18 quarterly MDS assessment showed the resident had a significant decline in ADL functional levels. The areas of bed mobility, transfers, locomotion on the unit, dressing, toilet use, and hygiene were shown to require extensive assistance from staff. Interview with the MDS coordinator on 4/12/18 at 9:34 AM revealed the resident had experienced a hip fracture on 1/27/18 and she had not completed a significant change assessment because she expected the resident to improve.	F 637	A change of condition MDS was completed for resident #29 with an ARD of 5/3/18. The comprehensive care plans were updated at this time as well. MDS coordinator to attend MDS certification course on 5/9-5/10/18. Course to include all needed topics to become certified in the MDS assessment process including significant change criteria. The MDS coordinator will address any concerns or questions regarding change in condition MDS with corporate MDS nurse. Any resident that is readmitted to the facility will be reviewed by MDS coordinator and IDT team to assess need for change in condition MDS. Care plan audit to be completed by MDS coordinator on all current residents to ensure care plans are appropriate, correct, and up to date. Audit to ensure no other significant change MDSs have been missed. If a care plan is found to be out of date, an additional assessment will be completed to update the care plan. Education to be provided by corporate MDS nurse to the IDT team regarding criteria for significant change assessment.	

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F 637	Continued From page 10	F 637	Potential changes in condition will be discussed by IDT team in morning census review meeting. Audit to be conducted by Administrator or designee for a period of 90 days to ensure needed change in condition MDSs are being completed when needed. Any concerns will be reported to the QA committee.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy review, review of Wyoming State law, and staff interview, the facility failed to meet professional standards of quality for 1 of 1 sample residents (#39) prescribed an illegal substance. The findings were: Review of the 3/19/18 "Drug Regimen Review" showed resident #39 had an order to receive the supplement cannabis sativa extract (CBD oil), 3 drops sublingually twice a day. The following concerns were identified: 1. Observation on 4/11/18 at 2:54 PM with LPN #1 showed a brown bottle with a dropper was stored in the narcotic lock box of the medication cart. The bottle was labeled "Angstromplex (phytocanniboid complex)." Interview with the LPN at that time revealed the bottle belonged to	F 658	Resident #39's CBD oil was returned to him/her on 4/12/18. Resident was instructed that this substance was no longer allowed in the facility and that he/she would have to return the substance to home. All resident charts were audited to ensure this substance is not ordered for any other resident. Facility procedure was put in place to discuss this substance. The CBD oil will not be allowed in the facility at this time. Practicing physicians at the facility have been notified of this procedure. Education provided to consultant pharmacist and to all staff by Director of	5/10/18

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F 658	Continued From page 11 the resident, and the resident's spouse brought the "supplement" from home. The LPN further stated the facility nurses brought the "supplement" to the resident and observed while the resident self-administered. 2. Review of the facility policy titled "Medications brought to the Facility by the Resident/Family" dated 5/22/1998 showed, "Drugs brought into the facility may not be administered until the following conditions have been met: a. State law and regulations allow such use.... The contents of each container must have been positively identified by a licensed physician or pharmacist." 3. Review of Article 19. Supervised Medical Use of Hemp Extracts (2015) showed the only legal use for CBD oil in Wyoming is for a diagnosis of intractable epilepsy or seizure disorder that does not respond to other treatment. Further, a registration card must be obtained from the state department of health and signed by a neurologist that specified a diagnosis of epilepsy or seizure disorder as the reason for usage. The law also specified the composition of the supplement must contain less than three-tenths of a percent (0.3%) tetrahydrocannabinol by weight, and be composed of at least five percent (5%) cannabidiol by weight, and contain no other psychoactive substance. 4. Review of the entire medical record showed the resident had no diagnosis of epilepsy or seizure disorder, and no evidence the resident had a registration card as required. 5. Phone interview with the pharmacist on 4/12/18 at 10:14 AM revealed he had verbally expressed concerns with the facility's psychoactive	F 658	Nursing on 5/10/18. Audits of each resident's medication regimen will be conducted on a monthly basis by the consultant pharmacist or designee. Consultant pharmacist will also verify contents of any medications brought by a resident from home prior to resident usage. If contents cannot be verified, resident will be asked to take items out of facility or contents will be destroyed per facility policy. Admission process updated to include audit for this substance by the admission team to ensure no other residents are admitted with this order. Admission checklist updated to include prohibited substances in the facility. Ongoing order triple check process to ensure orders for this substance are not received/acted upon for existing residents. Any concerns regarding orders received will be addressed by Director of Nursing to prescribing provider. The results of the consultant pharmacist audits will be brought to the QA committee by the DON as an ongoing process to ensure compliance.	

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F 658	Continued From page 12 medication team prior to the resident's admission. These concerns included interactions between cannabis sativa extract, sertraline, and amitriptyline which included increased heart rate, hypertension, and in rare cases aggressive behavior. He stated that he also brought up a concern that cannabis sativa extract was not legal to order in the state of Wyoming. He stated he never ordered cannabis sativa extract and he obtained information from on-line research. He also stated there would be no way to confirm the exact concentrations of active ingredients in the bottle, as the product varies in potency among different producers. He further stated cannabis sativa extract is not tested and regulated by any governmental regulatory body. 6. Review of the Wyoming Nurse Practice Act showed the following: "33-21-146. Disciplining licensees and certificate holders; grounds. (a) The board of nursing may refuse to issue or renew, or may suspend or revoke the license or temporary permit of any person, or to otherwise discipline a licensee or certificate holder upon proof the person: ...(v) Has engaged in any unauthorized possession or unauthorized use of a controlled substance as defined in the Wyoming Controlled Substances Act."	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		5/17/18

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F 684	Continued From page 13 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure timely medical intervention for a resident with a worsening condition for 1 of 1 sample residents (#7) who experienced a fall with significant injury. The findings were: Review of the 1/12/18 quarterly MDS assessment showed resident #7 had diagnoses which included muscle weakness, TIA (transient ischemic attack) history, altered mental status, and unspecified dementia. Further, the resident had a BIMS score of 5 (indicating severe cognitive impairment). Review of the 1/26/18 "Post Fall Evaluation" showed the resident had an unwitnessed fall on 1/26/18 at 4 AM. Further review showed the facility completed vital signs and neurological assessments by 4:23 AM. The following concerns were identified: a. Further review of the 1/26/18 "Post Fall Evaluation" showed the resident had pain on the left side after the fall. Medical record review showed the facility failed to complete any further comprehensive assessments of the resident after the initial post-fall assessment. The review showed a physician order dated 1/26/18 at 3:30 PM to transfer the resident to the emergency room for left lower extremity and hip pain (11 hours and 7 minutes after the initial assessment). b. Review of a 1/26/18 nursing note titled "Final Report", timed 4:15 PM, revealed the following: "Last evening this resident had an unwitnessed fall. The staff attended to [him/her], [s/he] seemed normal and not in significant pain. They followed procedure and documented it and	F 684	Resident #7 was sent to acute care facility for evaluation following his/her fall. No evidence of neurologic injury was present per documentation from acute care facility. An audit was completed on all falls from 1/1/18. No resident who suffered an un-witnessed fall had any indications of neurologic injury in the post-fall monitoring period. Facility policy implemented to ensure neuro-checks are completed on any un-witnessed fall for 72-hours post fall. In-service conducted by DON with nursing staff on 5/10/18 to educate on the requirement of neuro checks following an un-witnessed fall. DON or designee to audit medical records for any resident having a fall to ensure neuro checks are completed for any un-witnessed falls. These audits will take place weekly and be conducted ongoing. Any concerns will be reported to QA committee.	

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F 684	Continued From page 14	F 684		

told me when I arrived in the morning. At approximately 0700 [7 AM] this morning the resident didn't want to get up for breakfast which was unusual. I took [his/her] medications to [him/her] and [s/he] was c/o [complaining of] pain. I gave [him/her] tylenol and [s/he] laid back in bed with no complaints. At 0930 [9:30 AM] the resident needed to get up to the restroom and [s/he] was barely able to support [his/her] own weight. At this point I called [his/her] physician to request an evaluation or a trip to the ER for an evaluation. I spoke to [physician service staff] and she assured me she would get the message to the physician. At 1315 [1:15 PM] I still had not heard from the physician and I called them back, apparently, the entire staff was at lunch and I left a message with his answering service. When they called me back it was approximately 1400 [2 PM] and I was told that they had no record of my previous call, just the fax at night saying there was no visible injury. I explained the situation saying the residents condition appears to be worsening and that the residents [family] was concerned. I was, again, assured that the message would be given to the physician. More than an hour went by with no call or orders from the physician and the resident was now not able to even sit up in [his/her] wheelchair without assistance. I talked to the residents son and he wanted his [parent] to go to the ER, I called the physicians office and told the staff what was going on, how long we had waited for orders and that the family member was tired of waiting and that the resident was being sent to the ER. I called the ER and gave [name], the ER nurse, report on the condition of the resident, I printed out rounds report and documented all that has been happening today with the resident and then assisted with the transfer of the resident to the

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F 684	Continued From page 15 ER..." c. Interview with the DON on 4/11/18 at 3:30 PM showed the facility did not routinely continue with additional comprehensive assessments, which included neurological assessments, if they were at baseline after a fall, which included unwitnessed falls. Her expectation was to continue assessments as needed for the situation, and vital signs once per shift which included temperature, pulse, respirations, and blood pressure. d. Review of the policy titled, "Accidents and Incidents" last revised 12/14/16, "...3. Medical Attention: The charge nurse shall: a. Examine all accident/incident victims, b. Notify the residents attending physician and family, c. If necessary, transfer the injured person to the nearest medical facility, d. If necessary or appropriate, designate an employee to accompany the victim to the nearest medical facility."	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		5/10/18

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F 756	Continued From page 16 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, state law review, and policy review, the facility failed to ensure a medication irregularity was identified for 1 of 7 sample residents (#39) reviewed for unnecessary medications. Resident #39 was prescribed and received a substance that was illegal according to State law. The finding were: Review of the 3/20/18 admission MDS assessment showed resident #39 had diagnoses which included hypertension, gastroesophageal reflux disease, wound infection, depression, and respiratory failure. Review of the 3/19/18 "Drug Regimen Review" showed the resident had	F 756	Resident #39's CBD oil was returned to him/her on 4/12/18. Resident was instructed that this substance was no longer allowed in the facility and that he/she would have to return the substance to home. All resident charts were audited to ensure this substance is not ordered for any other resident. Facility procedure was put in place to discuss this substance. The CBD oil will not be allowed in the facility at this time. Practicing physicians at the facility have	

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F 756	Continued From page 17 medications ordered which included cannabis sativa extract (CBD oil) 3 drops sublingually twice a day, sertraline 200 milligrams orally daily, and amitriptyline 100 milligrams orally daily at bedtime. The following concerns were identified: a. Further review of the 3/19/18 "Drug Regimen Review" showed the following recommendations to nursing: "Please check Vanco Trough every 2-3 days. We don't have BMP and CBC (laboratory tests). Check as soon as possible." No other recommendations or irregularities were identified. b. Observation on 4/11/18 at 2:54 PM with LPN #1 showed a brown bottle with a dropper was stored in the narcotic lock box of the medication cart. The bottle was labeled "Angstromplex (phytocanniboid complex)." Interview with LPN #1 at that time revealed the bottle belonged to the resident, and resident's spouse brought the "supplement" from home. c. Review of Article 19. Supervised Medical use of Hemp Extracts (2015) showed the only legal use for CBD oil in Wyoming is for a diagnosis of intractable epilepsy or seizure disorder that does not respond to other treatment. Further, a registration card must be obtained from the state department of health and signed by a neurologist that specifies a diagnosis of epilepsy or seizure disorder as the reason for usage. The law also specified the composition of the supplement must contain less than three-tenths of a percent (0.3%) tetrahydrocannabinol by weight, and be composed of at least five percent (5%) cannabidiol by weight, and contain no other psychoactive substance. d. Review of the entire medical record showed the resident had no diagnosis of epilepsy or seizure disorder, and no evidence the resident had a registration card as required.	F 756	been notified of this procedure. Education provided to consultant pharmacist and to all staff by Director of Nursing on 5/10/18. Audits of each resident's medication regimen will be conducted on a monthly basis by the consultant pharmacist or designee. Consultant pharmacist will also verify contents of any medications brought by a resident from home prior to resident usage. If contents cannot be verified, resident will be asked to take items out of facility or contents will be destroyed per facility policy. Admission process updated to include audit for this substance by the admission team to ensure no other residents are admitted with this order. Admission checklist updated to include prohibited substances in the facility. Ongoing order triple check process to ensure orders for this substance are not received/acted upon for existing residents. Any concerns regarding orders received will be addressed by Director of Nursing to prescribing provider. The results of the consultant pharmacist audits will be brought to the QA committee by the DON as an ongoing process to ensure compliance.	

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F 756	Continued From page 18 e. Review of the policy titled, "Medications brought to the Facility by the Resident/Family" dated 5/22/1998 showed, "Drugs brought into the facility may not be administered until the following conditions have been met: a. State law and regulations allow such use...e. The contents of each container must have been positively identified by a licensed physician or pharmacist." f. Phone interview with the pharmacist on 4/12/18 at 10:14 AM revealed he had verbally expressed concerns with the facility's psychoactive medication team prior to the resident's admission. These concerns included interactions between cannabis sativa extract, sertraline, and amitriptyline which included increased heart rate, hypertension, and in rare cases aggressive behavior. He stated that he also brought up a concern that cannabis sativa extract was not legal to order in the state of Wyoming. He stated he never ordered cannabis sativa extract and he obtained information from on-line research. He also stated there would be no way to confirm the exact concentrations of active ingredients in the bottle, as the product varies in potency, and cannabis sativa extract is not tested and regulated by any governmental regulatory body. He confirmed he failed to document these concerns on the 3/19/18 "Drug Regimen Review" or anywhere else in the medical record. Further, he confirmed these concerns should have been documented.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		5/24/18

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F 757	Continued From page 19 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 3 of 7 sample residents (#8, #20, #28) who received psychotropic medications had adequate indications for use. The findings were: 1. Review of the 1/12/18 quarterly MDS assessment showed resident #8 had diagnoses which included unspecified dementia, anxiety, and depression; received an antipsychotic and antidepressant 7 days of the look-back period; and exhibited no psychosis, delusions, or behaviors. The following concerns were identified: a. Review of the 2/15/18 Drug Regimen Review showed the pharmacist wrote "Nursing: verify dx [diagnosis] of Zyprexa [an antipsychotic medication]." A note signed by the DON on 2/22/18 showed "dx-delusions". The physician	F 757	Facility requested the physician for resident #8 provide supporting documentation for continued use of Zyprexa and/or provide documentation to include appropriate diagnosis for use of this medication. Resident #8 has recently had a successful gradual dose reduction (GDR) and psychotropic committee will continue to attempt additional GDRs as appropriate. Facility requested the physician for resident #20 provide supporting documentation for continued use of the antipsychotic and antianxiety medication and/or provide documentation to include appropriate diagnosis for use of this medication. Resident #20 has recently had a successful GDR and psychotropic	

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F 757	Continued From page 20 signed the reply and checked "The above suggestion is noted; please do not take action at this time," but did not provide any additional justification for the medication. 2. Review of the 2/19/18 admission MDS assessment showed resident #20 had diagnoses which included unspecified dementia and anxiety; received an antipsychotic and antianxiety medication 5 days of the 7 day look-back period; had delusions; and exhibited physical and verbal behaviors directed toward others and behaviors not directed toward others 1 to 3 days of the look-back period. Review of the admission orders dated 2/9/18 showed the resident was admitted on "comfort care." The following concerns were identified: a. Review of physician orders showed the resident was prescribed risperidone (an antipsychotic medication) 1 mg twice daily with a start date of 2/12/18 for "unspecified dementia with behavioral disturbance." b. Review of the care plan initiated 3/4/18, in the category of "Psychotropic Medication Use," showed the resident took risperidone related to dementia with violent behaviors and was at risk for adverse effects. The expectation was the resident remain alert. A result dated 3/26/18 at 2:20 PM and additionally on 4/2/18 at 10:22 PM showed the resident was lethargic. c. Review of the care plan initiated 3/4/18, in the category of "Behavioral Symptoms," showed the resident was at risk for behaviors related to dementia and anxiety. Documentation of behaviors other than the expectation of "Appropriate or Calm or Cooperative" occurred on 3/7/18 at 2:33 PM (Agitated, Anxious, Crying, Disruptive social interaction, Impulsive, Irritable, Restless, Uncooperative) and on 4/6/18 at 1:01	F 757	committee will continue to attempt additional GDRs as appropriate. Facility requested the physician for resident #28 provide supporting documentation for continued use of Risperidone and/or provide documentation to include appropriate diagnosis for use of this medication. Resident #28 will be reviewed at upcoming psychotropic meeting on 5/23/18 to evaluate for potential GDR. Any resident on an antipsychotic medication has been audited by psychotropic committee to ensure that appropriate diagnosis and/or supporting documentation is in place. Admission criteria has been revised to ensure appropriate diagnoses are in place for all psychotropic medications. Facility Administrator and Director of Nursing to provide education to physician on 5/9/18 regarding use of psychotropic medications and adequate indications for use. Education provided by the DON to nursing staff on 5/10/18 regarding medication usage. DON also provides, on an ongoing basis, education to residents/resident representatives regarding medication usage, proper diagnoses, and gradual dose reduction requirements. DON or designee will audit monthly to ensure compliance. Any concerns will be reported to the QA committee.	

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F 757	Continued From page 21	F 757		

PM (verbally aggressive.)

d. Review of the medical record showed no physician rationale was provided for the use of the antipsychotic medication.

3. Review of the 3/4/18 quarterly MDS assessment showed resident #28 had diagnoses which included dementia and bi-polar disease. The review showed the resident received antipsychotic medication for 7 of 7 consecutive days. Review of the medical record showed a 5/15/17 order for risperidone (anti-psychotic) 1 milligram daily by mouth for unspecified dementia with behavioral disturbance. The following concerns were identified:

a. Review of the medical record showed the facility failed to specify the behaviors for which the resident received risperidone. Review of the care plan showed, "Appropriate behaviors with no side effects from Psychotropic...Staff will monitor my behaviors at least once per shift and as needed."

b. Review of the 12/18/17 "Drug Regimen Review" showed the pharmacist wrote, "Nursing: Need valid DX [diagnosis] for risperidone." The physician signed the reply and checked, "The above suggestion is noted; please do not take action at this time." Review of the 1/22/18 "Drug Regimen Review" showed the pharmacist wrote, "Nursing: Problem DX [diagnosis] on risperidone." The physician signed the reply and checked, "The above suggestion is noted; please do not take action at this time." Review of the 2/16/18 "Drug Regimen Review" showed the pharmacist wrote, "Nursing: Verified DX [diagnosis] for risperidone." The physician signed the reply and checked, "I agree with the above suggestions: please implement." The physician wrote "Bi-Polar" under the pharmacist recommendation. However, the

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F 757	Continued From page 22 facility failed to ensure documentation of rationale with specific behaviors for use of risperidone, which the resident had received since 5/15/17 (seven months before a diagnosis of bi-polar was identified as a reason for the medication). The facility further failed to document a rationale or perform a risk-benefit analysis for continued use of the medication at the 5/17/17 ordered dosage without an attempt to perform a GDR. 4. Interview with the DON on 4/12/18 at 1:44 PM revealed there was no further documentation available from the physician related to the use of the antipsychotics.	F 757		
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80);	F 836		5/10/18

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	535038	A. BUILDING _____ B. WING _____	04/12/2018

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F 836	Continued From page 23 nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, State law review, and policy review, the facility failed to ensure State laws were followed concerning 1 of 1 sample resident (#39) reviewed for supplement orders. The finding were: Review of the 3/20/18 admission MDS assessment showed resident #39 had diagnoses which included hypertension, gastroesophageal reflux disease, wound infection, depression, and respiratory failure. Review of the 3/19/18 "Drug Regimen Review" showed the resident had medications ordered which included the supplement cannabis sativa extract (CBD oil) 3 drops sublingually twice a day. The following concerns were identified: a. Further review of the 3/19/18 "Drug Regimen Review" showed the supplement cannabis sativa extract (CBD oil) was identified. However, no recommendations or irregularities were identified concerning this supplement. b. Observation on 4/11/18 at 2:54 PM with LPN #1 showed a brown bottle with a dropper was in the narcotic lock box of the medication cart. The bottle was labeled "Angstromplex	F 836	Resident #39's CBD oil was returned to him/her on 4/12/18. Resident was instructed that this substance was no longer allowed in the facility and that he/she would have to return the substance to home. All resident charts were audited to ensure this substance is not ordered for any other resident. Facility procedure was put in place to discuss this substance. The CBD oil will not be allowed in the facility at this time. Practicing physicians at the facility have been notified of this procedure. Education provided to consultant pharmacist and to all staff by Director of Nursing on 5/10/18. Audits of each resident's medication regimen will be conducted on a monthly basis by the consultant pharmacist or designee. Consultant pharmacist will also verify contents of any medications brought	

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F 836	Continued From page 24 (phytocanniboid complex)." Interview with the LPN at that time revealed the resident's spouse brought the "supplement" from home. He stated nurses brought the supplement to the resident and observed him/her self-administer. He further revealed the facility utilized a "sign-out" form to document each time the resident self-administered the supplement. c. Phone interview with the pharmacist on 4/12/18 at 10:14 AM revealed he had verbally expressed concerns with the facility's psychoactive medication team prior to the resident's admission. He stated the concerns included the fact that cannabis sativa extract was not legal to order or administer in the state of Wyoming. He stated he never ordered cannabis sativa extract, and he obtained information from on-line research. He also stated there would be no way to confirm the exact concentrations of active ingredients in the bottle, as different producers of the product vary in potency, and cannabis sativa extract is not tested and regulated by any governmental regulatory body. d. Review of Article 19. Supervised Medical use of Hemp Extracts (2015) showed the only legal use for CBD oil in Wyoming is for a diagnosis of intractable epilepsy or seizure disorder that does not respond to other treatment, and a registration card must be obtained from the state department of health and signed by a neurologist that specifies a diagnosis of epilepsy or seizure disorder as the reason for usage. The law also specified the composition of the supplement must contain less than three-tenths of a percent (0.3%) tetrahydrocannabinol by weight, and be composed of at least five percent (5%) cannabidiol by weight, and contain no other psychoactive substance. e. Review of the entire medical record	F 836	by a resident from home prior to resident usage. If contents cannot be verified, resident will be asked to take items out of facility or contents will be destroyed per facility policy. Admission process updated to include audit for this substance by the admission team to ensure no other residents are admitted with this order. Admission checklist updated to include prohibited substances in the facility. Ongoing order triple check process to ensure orders for this substance are not received/acted upon for existing residents. Any concerns regarding orders received will be addressed by Director of Nursing to prescribing provider. The results of the consultant pharmacist audits will be brought to the QA committee by the DON as an ongoing process to ensure compliance.	

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F 836	Continued From page 25 showed the resident had no diagnosis of epilepsy or seizure disorder, and no evidence the resident had a registration card as required. f. Review of the policy titled, "Medications brought to the Facility by the Resident/Family" dated 5/22/1998 showed, "Drugs brought into the facility may not be administered until the following conditions have been met: a. State law and regulations allow such use...e. The contents of each container must have been positively identified by a licensed physician or pharmacist."	F 836		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		5/17/18

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F 880	Continued From page 26	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 27 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure effective personal protective equipment (PPE) was used for processing soiled linens in 1 of 1 laundry room. The findings were: Interview with a laundry aide on 4/12/18 at 4:04 PM revealed she used a cloth-type jacket for handling contaminated linen items. Observation of the jacket with the maintenance manager showed it was not fluid resistant. Water was applied to the cloth and was immediately absorbed by the material. Interview with the DON who was responsible for infection control on 4/12/18 at 4:30 PM confirmed proper PPE should be worn when working with soiled linens.	F 880	A new laundry sorting coat was ordered on 5/3/18 to meet the permeability requirements. The laundry staff were in-serviced by maintenance director on 4/25/18 that they are to use this coat and other appropriate PPE while sorting soiled linens. The sorting coat will be inspected quarterly for permeability by maintenance staff. Should coat fail inspection, a new sorting coat will be purchased. This inspection has been added to the TELS preventative maintenance program and will be documented on a quarterly basis. Maintenance director will conduct random audits for a period of 90 days to ensure the sorting coat is being worn appropriately. Any issues identified during this audit will be addressed with the infection control nurse and with the QA committee.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.	F 881		5/17/18

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F 881	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of policy and procedure, and review of McGeer Criteria, the facility failed to ensure an antibiotic stewardship program was implemented to monitor antibiotic use. The census was 48. The findings were: 1. Review of the 1/1/18 quarterly MDS assessment showed resident #43 had a BIMS score of 15/15 (cognitively intact), was frequently incontinent of urine, had diagnoses which included end stage renal disease, and received dialysis. The following concerns were identified: a. Review of a nurse's note dated 4/6/18 showed "Resident had assessment. All assessments were compliant with resident's baselines and were WNL [within normal limits] except that resident has edema BLE [bilateral lower extremity]. Resident also c/o [complains of] burning upon urination and stated 'I have a UTI [urinary tract infection]'" b. Review of the medical record showed a urinalysis was completed on 4/4/18 and showed positive for leukocyte esterase, white blood cells, and bacteria. There was no evidence a culture and sensitivity was ordered. c. Review of physician orders showed amoxicillin (an antibiotic) was ordered with a start date of 4/10/18 and a stop date of 4/23/18. d. Interview with the DON on 4/12/18 at 3:40 PM revealed the resident had complained of urinary retention, burning, and flank pain, but no fever. The resident had requested the physician be called and an antibiotic ordered. The DON confirmed there was no culture ordered and there was not any justification from the physician for the use of the antibiotic.	F 881	Resident #43 was educated by nursing staff regarding appropriate use of antibiotics and the risk vs benefits of antibiotic use and possibilities of multi-drug resistance. An audit of all residents who were prescribed antibiotics in past 90-days was conducted to ensure proper criteria were met prior to antibiotic administration. DON and Administrator to meet with resident physician on 5/9/18 to discuss antibiotic stewardship program and provide education regarding antibiotic usage. In-service for nursing staff conducted on 5/10/18 regarding antibiotic usage and McGeer Criteria. Director of Nursing to provide education to nursing staff. Nursing staff to assess residents using McGeer Criteria prior to requesting treatment from physician. DON or designee to conduct monthly audit of antibiotic usage to ensure proper criteria are being met and to ensure compliance with antibiotic stewardship program. Audit to continue on monthly basis as part of infection control program. Any concerns will be addressed with the QA committee.	

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F 881	Continued From page 29 2. Review of the policy titled "Antibiotic Stewardship" with an effective date of 11/17/17 showed "...Procedures 1. Support and promote antibiotic use protocols which include: a. Assessment of residents for infection using standardized tools and criteria. The criteria used by this facility are adapted from the McGeer Criteria." 3. According to the "Revised McGeer Criteria for Infection Surveillance Checklist," to diagnose a UTI without an indwelling catheter the resident must fulfill criteria in two sections. The first section criteria consists of positive symptoms and bloodwork and the second section criteria consists of a positive urine culture.	F 881		