STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 4/23/18 to 4/26/18. Also reviewed in the course of the survey was complaint intake WY000002411. The following common abbreviations are used throughout this document: DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	F 582: Advanced Beneficiary Notices (CMS-10055 SNFABN) will be provided to Medicare beneficiary, or authorized representative, before extended care services or items are furnished, reduced, or terminated. The notices will be issued when the WRC believes that Medicare will not pay for, or will not continue to pay for, extended care services that the SNF furnishes. Notice of Medicare Non-Coverage (CMS-10123 NOMNC) will be provided to Medicare beneficiary, or authorized representative, to all beneficiaries eligible for the expedited determination process per CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 260.2.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582	. Resident #66 continued to receive services after the skilled nursing stay. Resident #66 services received after the skilled nursing stay are currently covered by Wyoming Medicaid. . Review of current resident census shows one resident is currently receiving Medicare covered skilled nursing services. This resident has been provided with form CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) on 05/24/2018. The beneficiary is not eligible for the expedited determination process at this time and does not require form CMS-10123. The original was filed in resident medical file and a copy given to the resident and their representative.	6/15/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristine J. Schmidt | TITLE: Director of Nursing | (X6) DATE: 5/31/18

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.

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F 582	Continued From page 1 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) and Notice of Medicare Non-Coverage (NOMNC) form to 1 of 1 sample residents (#66) reviewed with a Medicare Part A stay. The findings were:	F 582	All residents who have Medicare covered skilled nursing services have the potential to be affected by the deficient practice. The MDS Coordinator and Business Office Manager were educated on the Medicaid/ Medicare Coverage/Liability Notice requirements on 5/24/18. A Medicare Triple-Check process will be implemented to review Medicare skilled resident files for accuracy and completeness. Required notices will be reviewed during this audit to ensure they have been appropriately distributed to the resident, or authorized representative. Any problems identified will result in immediate education and corrective action. Completion Date 06/15/18. The Business Office Manager will report the results of the audits, and any problems identified, at the QAPI meetings. Reporting will occur monthly for at least three months or until ongoing compliance has been achieved.	6/15/2018

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F 582	Continued From page 2 Review of a "Determination of Continued Stay" form, dated 1/18/18, showed resident #66 had skilled nursing services provided under Medicare Part A from 1/8/18 through 1/14/18. Further review showed the resident's condition improved, and the facility believed the resident's stay would no longer be covered under Medicare Part A benefits as of 1/14/18. Additionally, this information was provided to the resident's guardian by telephone on 1/19/18. Interview with the business office manager on 4/26/18 at 10 AM revealed the facility issued a "Determination of Continued Stay" to residents when they were discharged from skilled services before benefits were exhausted. She further stated the resident remained at the facility, and confirmed the facility did not issue a Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) or a Notice of Medicare Non-Coverage (CMS-10123) to the resident or his/her guardian.	F 582		
F 623 SS=D	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	F 623	F 623: The facility will ensure a transfer/discharge notice is provided to the resident and the resident's representative. The facility will send a copy of the notice to the Office of the State Long-Term Care Ombudsman in accordance with 483.15(c)(3). Notices will be sent at least 30 days before a resident is transferred or discharged, or as soon as practicable when (1) The safety of individuals in the facility would be endangered, (2) The health of individuals in the facility would be endangered, (3) The resident's health improves sufficiently to allow a more immediate transfer or discharge, (4) An immediate transfer or discharge is required by the resident's urgent medical needs, (5) A resident has not resided in the facility for 30 days.	

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F 623	Continued From page 3 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; (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	F 623	Resident #25 returned to the facility and has no plans for discharge at this time. . All residents who transfer/discharge have the potential to be affected by the deficient practice. Review of the current resident census shows no residents are planned for facility-initiated transfer or discharge. . The Social Services Manager was educated on the Notice Requirements Before Transfer/ Discharge regulations on 5/22/18. The transfer/ discharge notice will be developed to ensure the contents of the transfer/discharge notice is in accordance with 483.15(c)(5). WRC Policy-9 RESIDENT TRANSFER OR DISCHARGE and procedures will be reviewed and updated to ensure all residents who are facility-initiated transfers or discharges receive transfer/ discharge notice. All nursing staff will be educated on the transfer/discharge policy and procedure. The Social Services Manager or designee will provide transfer/discharge written notice to all residents and resident representative upon transfer or discharge and will document delivery in the medical record. A copy of the notice will be sent to the Long-Term Care Ombudsman. If unable to provide the transfer/discharge notice before transfer the attempt to provide transfer/discharge notice to the intended recipient will be documented in the resident's medical record, and the notice will be given as soon as practicable, and documented in the medical record. Completion Date 06/15/18.	6/15/2018

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F 623	Continued From page 4 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 (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	F 623	The Social Services Manager or designee will audit all transfer/discharge records on the first business day after departure to ensure the transfer/discharge notice was provided to the resident and resident representative, and placed in the resident's medical record. The audits will continue for at least 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The Social Services manager will report the results of audits, and any problems identified, at the QAPI meeting. Reporting will occur monthly for at least three months or until ongoing compliance has been achieved.	6/15/2018

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F 623	Continued From page 5 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/discharge notice was issued to 1 of 1 sample residents (#25) reviewed for transfer/discharge. The findings were: Review of the medical record showed resident #25 was transferred to the hospital with an acute condition on 2/6/18 and returned to the facility on 2/8/18. Further review of the medical record showed no evidence a transfer/discharge notice was given to the resident or his/her representative. Interview on 4/25/18 at 8:58 AM with the DON and MDS coordinator verified the resident was not given a transfer/discharge notice upon transfer out of the facility. In addition, they stated they were not aware of this requirement.	F 623	F 625: The facility will ensure a written notice of bed-hold policy is provided to the resident and the resident representative upon admission and before a transfer in accordance with 483.15(d)(1)(2). Resident #25 returned to the facility and is a current resident. All residents who transfer have the potential to be affected by the deficient practice. All residents were provided with a copy of the facility's bed-hold policy upon admission and will be given a copy before transfers to ensure compliance with providing a written notice of bed hold policy before transfer. Review of the current resident census shows no residents are planned for transfer to a hospital or therapeutic leave at this time. The Social Services Manager was educated on the Notice of Bed-Hold Policy Before/Upon Transfer regulations on 5/22/18. The bed-hold notice will be developed to ensure the contents of the bed-hold notice is in accordance with 483.15(c)(5). WRC Policy-14 BED HOLD Policy and procedures will be reviewed and updated to ensure all residents receive a bed-hold notice upon admission and before transfer. All residents will receive a copy of the updated bed-hold notice. Completion Date 06/15/18.	6/15/2018
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state	F 625		

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F 625	Continued From page 6 plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure a bed-hold notice was issued to 1 of 1 sample residents (#25) reviewed for transfer/discharge. The findings were: Review of the medical record showed resident #25 was transferred to the hospital with an acute condition on 2/6/18 and returned to the facility on 2/8/18. Further review of the medical record showed no evidence a bed-hold notice was given to the resident or his/her representative. Interview on 4/25/18 at 8:58 AM with the DON and MDS coordinator verified the resident was not given a notice of bed-hold policy upon transfer out of the facility. In addition, they stated they were not aware of this requirement.	F 625	All nursing staff will be educated on the policy and procedure for providing a bed-hold notice. The Social Services Manager or designee will provide a written bed-hold notice to the resident and resident representative upon admission and transfer, or in cases of emergency transfer, within 24 hours, and will document delivery in the medical record. If unable to provide the bed-hold notice before transfer the resident's medical record will reflect the attempt to provide the bed-hold notice to the intended recipient, and the notice will be given as soon as practicable and documented in the medical record. Completion Date 06/15/18. The Social Services Manager or designee will audit all transfer/discharge records on the first business day after departure to ensure the bed-hold notice was provided to the resident and resident representative, and documented in the resident's medical record, for no less than 3 months to ensure compliance. Any problems identified will result in immediate education and corrective action. The Social Services Manager will report the results of audits, and any problems identified, at the QAPI meeting. Reporting will occur monthly for no less than three months or until ongoing compliance has been achieved.	6/15/2018
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755	F755: It is the policy of this facility to review medication expiration dates and to initial/date medications when opened.	

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F 755	Continued From page 7 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to ensure medications available for resident use were not past the manufacturer's recommended expiration dates in 1 of 1 medication rooms (north unit) reviewed. In addition, the facility failed to ensure medications were labeled with expiration	F 755	Because all residents receiving medications are potentially affected by cited deficiency F755, on 4/26/2018 a medication audit was completed by nursing services stocker for both expired medications and for opened insulin pens. No further expired medications were noted at this audit. Beginning June 1, 2018 a reminder will be placed under each insulin order on the MAR stating: 1. Each insulin pen must be initialed/ dated when opened and 2. Medication expires 28 days after opening On June 12, 2018, a nursing in-service will address expired medications, medication errors and the safe administration of medication. This training will emphasize safe medication administration. To enhance our currently compliant operations, a monthly audit will be completed by designated stocker for emergency medications, stock medications, OTC medications and lab supplies. The audit will be recorded on the Drug expiration log. DON or designee will report the results of the audits monthly, and any problems identified, at the monthly QAPI meeting. Reporting will occur monthly for at least three months or until ongoing compliance has been achieved.	6/15/2018

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F 755	Continued From page 8 dates once opened in 1 of 2 medication carts (white cart, north unit) reviewed. The findings were: 1. Observation on 4/26/18 at 10:14 AM of the north unit medication room showed two 10-ounce bottles of magnesium citrate solution that had expired, one bottle was labeled with an expiration date of 7/30/16 and one bottle was labeled with an expiration date of 12/10/16. Interview with the MDS coordinator at that time revealed the medications were available for resident use. 2. Observation of the north unit white medication cart on 4/26/18 at 10:03 AM showed 1 Lantus Solostar insulin pen open and available for use. Further review showed the pen was not labeled with an open date or an expiration date. Interview at that time with the MDS coordinator confirmed there was no date on the insulin pen. In addition, he stated insulin pens were to be dated when opened to ensure they were used within 28 days of opening. 3. Review of the manufacturer's instructions showed Lantus Solostar pens expired 28 days after opening or removing from the refrigerator.	F 755		
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.	F 756	F756: Failed to ensure pharmacy recommendation reports were acted upon for 2 residents 12/11/2017 and 2/04/2017. Per 483.45(c)4, Pharmacist must report any irregularities to the attending physician, DON, and Medical Director. These reports must be acted upon. On 4/26/2018, Pharmacy notes to attending physician were put in attending physicians' folder at the nurse station. Due to attending physicians' request of further information from pharmacist, signed orders from physician were received on 5/10/2018.	

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F 756	Continued From page 9 §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. (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 medical record review, staff interview, and review of facility documentation, the facility failed to ensure pharmacy recommendation reports were acted upon for 1 of 18 sample residents (#67) and 1 non-sample resident (#27). The findings were: 1. Review of a pharmacy recommendation report	F 756	Because all residents receiving medications are potentially affected by cited deficiency F756,To enhance and retain currently compliant operation, a determination was made of this system failure. F756 was due to pharmacy recommendations were sent to two different locations. Therefore, pharmacy communication labeled under "Note To Attending Physician/ Prescriber" will be sent by pharmacist to Director of Nursing Services and Medical Director and will be put in the attending physician order folder. Senior nurse participating in weekly physician rounds will ensure that physician orders are signed and noted. Monthly compliance audits will be completed at pharmacy meetings. DON or designee will report the results of the audits, and any problems identified, at the monthly QAPI meetings. Reporting will occur monthly for at least three months or until ongoing compliance has been achieved.	6/15/2018

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	535021	A. BUILDING _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 756	Continued From page 10 dated 2/4/18 for resident #67 showed "Resident started on rotating antibiotics for UTI prophylaxis. Please assess if continual therapy is appropriate for this resident..." There lacked evidence the physician had seen, or acted upon, the report. 2. Review of a pharmacy recommendation report dated 12/11/17 for resident #27 showed "Resident is receiving rotating antibiotics, amoxicillin, cephalexin, Macrobid, every month...please assess benefit vs risk of continuing indefinite antimicrobial therapy..." There lacked evidence the physician had seen, or acted upon, the report. 3. Review of a copy of an e-mail provided by the facility from the pharmacist dated 4/25/18 showed "We did not find the responses in the charts. I have asked several times about the requests to MDs [medical doctors] that we could not find, and whether they were given to the providers." 4. During an interview on 4/26/18 at 9:03 AM, the DON stated there was no evidence the reports were acted upon.	F 756	F760: Resident #24 plan of correction for medication error was implemented on 4/26/2018. Attending physician was contacted, an order for INR was received. Orders for Coumadin dosing were also received from attending physician. . All (5) residents receiving Coumadin are potentially affected by cited deficiency F760 on 4/26/2018. Upon the noted medication error of 04/11/2018, a plan of correction was implemented to prevent further medication errors and is currently implemented. 1. The Individual Anticoagulant sheet is now the first sheet in the residents' MAR. Anticoagulant sheet is on an eye-catching Gold colored paper . Anticoagulant therapy list of all residents is in the front of the MARs/TARs book and is a correlating eye-catching Gold colored form.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were free of significant medication errors for 1 of 18 sample residents (#24). The findings were:	F 760		

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F 760	Continued From page 11 1. Review of physician-faxed orders for resident #24 showed on 3/28/18 the physician was notified of an INR (international normalized ratio; a laboratory test to monitor treatment with blood thinning medication) of 1.8. The physician ordered Coumadin 5 mg every Wednesday and Coumadin 2.5 mg the rest of the days of the week, and to re-check the INR in 2 weeks (4/11/18). The following concerns were identified: a. Review of a fax to the physician dated 4/11/18 showed the INR was 1.0. The nurse made a note which read "According to the MAR [resident's name] did not receive the Coumadin 2.5 mg on 4/6, 4/7, 4/8...." b. Review of the April 2018 MAR confirmed the Coumadin was not documented as given on 4/6, 4/7, or 4/8. c. During an interview on 4/26/18 at 8:49 AM the DON confirmed it was a medication error and stated the facility had a broken system. She stated nurses were now going to have to sign off at the end of the shift that medications were given and documented. She stated this issue had not been looked at yet in their quality assurance program.	F 760	2. Designated Senior nurse will complete a monthly INR audit for residents given Coumadin. Results of the audits will be reported to QAPI monthly for the next 3 months or until ongoing compliance has been achieved. . 3. Daily MAR check by ongoing nurse for off-going nurse's MAR is completed for accuracy of medication documentation and prevention of medication errors. . 4. Monthly MAR audit by Medical records completed on May 7, 2018. MARs will continue to be audited monthly with review/counseling by Director of Nursing. Audit results will be reviewed at QAPI monthly for the next 3 months or until continued compliance is achieved. . 5. Nursing in-service scheduled for June 12, 2018 regarding medication administration and prevention of medication errors.	6/15/2018 6/15/2018
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced	F 770	F770: The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. The facility failed to ensure ordered laboratory tests were completed for 1(#21) resident. . Resident #21 Plan of Correction implemented immediately upon discovery on 4/26/2018. Attending physician was notified. INR drawn and attending physician was notified of the results. Attending physician orders received and implemented by nursing.	

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F 770	Continued From page 12 by: Based on medical record review and staff interview, the facility failed to ensure ordered laboratory tests were completed for 1 of 18 sample residents (#21). The findings were: Review of physician orders for resident #21 showed an order dated 4/2/18 for the resident to have an International Normalized Ratio (INR, blood test to monitor clotting time of the blood) repeated in 1 week. Review of the resident's medical record showed no evidence the INR was completed. Interview on 4/26/18 at 8:58 AM with the DON and MDS coordinator confirmed the order was missed. Further, they stated the order should have been transferred onto the MAR/TAR (treatment administration record). In addition, the order should have been double checked with the 24 hour chart check and they stated they didn't see that the double check was completed on that particular order.	F 770	All residents receiving orders for bloodwork are potentially affected by cited deficiency F770. 1. To prevent missed orders, all Physician orders received during physician rounds are now to be reviewed, noted, and taken off by the senior nurse accompanying the attending physician on rounds. This includes transferring the received order to the MAR/TAR by the senior nurse. 2. A weekly 24 hour chart check audit has been initiated on 5/23/2018 by Senior nurse x 3 months. These 24 hour chart audit reports will be reviewed by QAPI every month x 3 months or until ongoing compliance has been achieved. 3. Nursing In-service on June 5, 2018 will include 24 hour chart checks and anticoagulant therapy.	6/15/2018 6/15/2018
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	F812: Interview with the dietary manager included notification that the problem areas (2 of 3) were immediately addressed on 4/23. (No mention of metal cages took place during any interaction with surveyors therefore they were still dusty on 4/25/18) Metal cages were cleaned on 5/21 when staff became aware of the deficiency. . SOPC-05 was updated 5/24 to include frequency of cleanings of vents and to include light cages with fixtures and fire suppression nozzles. (attached)	5/24/2018

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F 812	Continued From page 13 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure clean and sanitary equipment in 1 of 1 kitchens. The findings were: Observation in the facility kitchen on 4/23/18 at 4:48 PM showed the hood vent above the stovetop had pipes hanging down. Further observation of the pipes showed an accumulation of dust particles and grease build-up. Continued observation showed the hood vents over the convection ovens had 3 lights with surrounding metal cages. These cages had accumulated dust build-up. Additional observation of the convection ovens showed the top surfaces of the ovens had a layer of dust and food particles or crumbs. Observation in the facility kitchen on 4/25/18 at 3:03 PM showed the pipes and light cages continued to have dust and grease build-up. Additionally, the top surfaces of the convection ovens continued to have dust and food particles. Further observation showed an oven rack and 2 oven mitts were placed on top of the convection ovens, directly on the soiled surface. Interview with the dietary manager on 4/25/18 at 4:19 PM confirmed the identified areas needed to be cleaned. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "... (C) NonFOOD-CONTACT	F 812	SOPC-36 was created to detail oven cleaning protocols, including all exterior surfaces. (attached) . No specific resident was identified as being adversely affected. All residents who have food served from the kitchen have the potential to be affected by the deficient practice. . Audit, developed by consultant RD is also attached. Audits and any problems identified will be submitted for review monthly at the QAPI meeting by the dietary manager or designee for at least three months or until ongoing compliance has been achieved.	5/24/2018

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F 812	Continued From page 14 SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."	F 812		