STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY LIVING AND REHABILITATION CENTER	1000 S DOUGLAS HWY GILLETTE, WY 82716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 10/22/18 through 10/25/18. Also reviewed during the course of the survey was complaint intake WY00002668. The following common abbreviations are used through this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MAR: Medication Administration Record MDS: Minimum Data Set mg: Milligrams PRN : meaning "when necessary" (from the Latin "pro re nata") Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds.	F 567		12/9/18

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

Electronically Signed | 11/16/2018

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

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F 567	Continued From page 1 (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and review of policy and procedure, the facility failed to provide residents access to personal funds on weekends. The census was 151. The findings were: 1. Review of the 8/15/18 annual MDS assessment showed resident #56 was cognitively intact with a BIMS score of 15. Interview on 10/23/18 at 12:54 PM with the resident revealed the facility did not provide access to personal funds on the weekends and the facility reminded residents to get needed money before the weekend. 2. Interview on 10/25/18 with the billing	F 567	Correction for cited residents/environment: Resident #56 1. Unable to correct for cited resident Identification of other residents: All residents have the potential to be affected by failure to access personal funds on weekends, holidays, and evening hours. Systematic changes and monitoring: -Education provided to nursing staff on 11/12/18 regarding resident ability to	

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F 567	Continued From page 2 supervisor revealed residents may withdraw funds Monday through Friday from 7:30 AM to 6:00 PM. She further stated residents did not have access to funds on weekends. 3. Review of the Resident Trust policy and procedure dated 7/28/17 revealed the hours personal funds were available to residents were not identified in the policy and procedure.	F 567	access funds 24/7. -Starting 11/13/18, person funds availability provided to residents by access on designated nursing cart for nights, weekends, and holidays. -Education to resident council members regarding availability of funds on 11/15/18. -Education to residents and families via facility newsletter that will be mailed out the week of December 3rd, 2018. -Resident Trust policy updated to reflect new facility practices and posted for staff access on 11/16/18. Outcome: 100% of residents will have access to resident funds every day of the week, 52 weeks of the year. Night, weekend, and holiday usage will be collected by billing supervisor (or designee) and will be aggregated and reported monthly at long term care meetings. All discrepancies will be investigated and reported.	
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	F 582		12/9/18

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F 582	Continued From page 3 (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 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.	F 582		

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F 582	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of beneficiary protection notice information and staff interview, the facility failed to ensure the required notices were provided for 2 of 3 residents (#67, #124) who were reviewed. The findings were: 1. Review of beneficiary protection notice information showed resident #67 had a Medicare part A skilled service episode start date of 8/16/18. The last covered day of this part A service was 8/22/18. The information in the facility letter to the resident showed the reason Medicare payment was ending was because it had been determined the resident no longer required the skilled services. However, no Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) was provided to the resident or the resident's representative. 2. Review of the beneficiary protection notice information showed resident #124 had a Medicare part A skilled service episode start date of 4/11/18. The last covered day of this part A service was 5/2/18. The information in the facility letter to the resident showed the reason Medicare payment was ending was because it had been determined the resident no longer required the skilled services. However, no Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) was provided to the resident or the resident's representative. 3. Interview on 10/25/18 at 10:16 AM with the billing supervisor and the administrator revealed they provided a letter with details and options for an appeal to the residents. However, they did not issue the Center for Medicare and Medicaid	F 582	Correction for cited resident/environment: Resident #67 Unable to correct for cited resident. ABN letter had been provided to resident however did not give CMS approved ABN notice. Resident #124 Unable to correct for cited resident. ABN letter had been provided to resident however did not give CMS approved ABN notice. Identification of other residents: All residents have the potential to be affected by failure to ensure the required notices are provided for Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN). Systematic changes and monitoring: -Detailed education provided to billing office staff on 11/16/18 regarding proper notice requirements. Education also provided to unit secretaries (who cover admissions on weekends) on 11/15/18 and 11/16/18. -General SNF ABN education provided at facility all staff meeting on 11/8/18. -Medicare Part A Admission Denial policy updated to reflect new facility practices and posted for staff access on 11/1/51/8. Outcome: 100% of residents who need a SNF ABN should be delivered with proper ABN form per CMS guidelines. This data will be collected by billing supervisor (or	

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F 582	Continued From page 5 Services (CMS) SNF ABN form.	F 582	designee) and will be aggregated and reported monthly at long term care meetings. All discrepancies will be investigated and reported.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, review	F 609	Correction for cited resident/environment:	12/9/18

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F 609	Continued From page 6 of the State Survey Agency incident log, staff interview, and review of policies and procedures, the facility failed ensure 1 of 9 incidents of suspected abuse reviewed was reported to the State Survey Agency as required. This incident involved residents #118 and #25. The findings were: Review of an investigation completed by the facility showed a resident-to-resident altercation involving resident #118 and #25 occurred on 10/22/18. Further review of the investigation showed resident #118 slapped resident #25. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. Interview on 10/25/18 at 2:30 PM with the administrative DON verified the incident had not been reported to the State Survey Agency. Review of the facility policies and procedure titled, "Reporting Abuse to Facility Management", approved 9/4/17, showed "When an alleged or suspected case of mistreatment, neglect, injuries unknown source, or abuse is reported, the facility administrator, or his/her designee" will notify the State Survey Agency within two hours of the alleged incident.	F 609	Resident #118 Initial report entered in OHLS incident reporting system on 10/25/18 when event discovered. Resident #25 Initial report entered in OHLS incident reporting system on 10/25/18 when event discovered. Identification of other residents: All residents have the potential to be affected by failure to timely report suspected abuse or allegations of abuse. Systematic changes and monitoring: - Abuse policy reviewed on 11/8/18 and no changes needed. - Staff education completed at facility all staff meeting on 11/8/18. - Nursing education completed at nursing meeting on 11/12/18. - House supervisor/leadership education completed on 11/13/18 regarding timelines and how to report in online system. Outcome: 100% of reported allegations of abuse or suspected abuse will be reported within the federal regulation of two hours. This data will be collected by social services (or designee) and will be aggregated and reported monthly at long term care meetings. All discrepancies will be investigated and reported.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		12/9/18

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F 623	Continued From page 7 §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; (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	F 623		

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F 623	Continued From page 8 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 (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	F 623		

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F 623	Continued From page 9 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 written transfer notice which contained all required elements was provided for 5 of 5 sample residents (#67, #121, #122, #127, #131) who were transferred to the hospital. The findings were: 1. Review of medical records showed the following: a. Resident #67 was transferred to the emergency room (ER) on 8/13/18. b. Resident #121 was transferred to the ER on 10/7/18. c. Resident #122 was transferred to the ER on 10/12/18. d. Resident #127 was transferred to the ER on 10/7/18 and again on 10/13/18. e. Resident #131 was sent to the ER. 2. Review of the transfer notices provided by the facility revealed no transfer notice for resident	F 623	Correction for cited resident/environment: Resident #67 Unable to correct for cited resident Resident #121 Unable to correct for cited resident Resident #122 Unable to correct for cited resident Resident #127 Unable to correct for cited resident Resident #131 Unable to correct for cited resident Identification of other residents: All residents have the potential to be affected by failure to provide a notice of transfer to resident/resident representative when transferred to the hospital. Systematic changes and monitoring: - Revision of bed hold/transfer form on 11/12/18 to include all required elements	

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F 623	Continued From page 10 #122. Review of the transfer notices for residents #67, #121, #127, and #131 revealed the notices were missing some of the required elements. The notices failed to contain: the effective date of the transfer, the location to which the resident was transferred, and contact information for the agencies responsible for protection and advocacy of individuals with developmental disabilities or with a mental disorder. 3. During an interview on 10/24/18 at 1:57 PM the administrative DON stated she was unable to find the transfer notice for resident #122. In addition, she confirmed the transfer notices for residents #67, #121, #127 and #131 did not contain all of the required elements.	F 623	which includes the following: effective date of transfer, location to which the resident transferred, contact information for the agencies responsible for protection and advocacy of individuals with developmental disabilities or with a mental disorder. - General education at facility all staff meeting on 11/8/18. - Specific education at nursing unit meeting on 11/12/18. - Transfer/Discharge policy updated to reflect new facility practices and posted for staff access on 11/15/18. Outcome: 100% of facility initiated transfers will be completed with all required elements of transfer. This data will be collected by Director of Nursing(or designee) and will be aggregated and reported monthly at long term care meetings. All discrepancies will be investigated and reported.	
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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		12/9/18

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F 684	Continued From page 11 Based on resident and staff interview, and review of the medical record, the facility failed to implement a bowel management program for 1 of 1 sample residents (#145) with constipation concerns. In addition, the facility failed to effectively monitor blood sugar and insulin treatment for 1 of 5 sample residents (#131) who required diabetic monitoring. The findings were: 1. Review of the 10/19/18 care plan showed resident #145 had identified problem areas which included immobility, pain, and hospice care. Further, the resident had altered communication and used a tablet computer to communicate. The resident understood communication, and answered yes or no and used hand gestures. Interview with the resident on 10/23/18 at 9:46 AM revealed a side effect of his/her pain medication was constipation. The resident revealed his/her constipation was not being managed effectively. Review of the October 2018 MAR showed the resident received routine and PRN Morphine, a narcotic pain medication which can cause constipation. Review of the 9/28/18 physician signed orders showed a bowel protocol where on day 2 of no bowel movement (BM) Milk of Magnesia 30 ml twice a day as needed was to be administerred. On day 3 "Biscodyl 5mg 1 tab PO [by mouth] daily prn [as needed] may repeat x1 if no BM OR Biscodyl 10 mg suppository one time daily prn [as needed]; Day 4 notify physician if no BM." The following concerns were identified: a. Review of the October 2018 bowel tracking documentation showed the resident did not have a bowel movement for 6 days from 10/15/18 to 10/21/18. b. Review of the October 2018 MAR showed the resident received milk of magnesia 30 ml on 10/19/18 (Day 4 of no BM) and on Day 5	F 684	Correction for cited resident/environment: Resident #145 - Unable to correct for timeframe reviewed (10/15/18 to 10/21/18) - Plan of care updated 11/16/18 to reflect residents constipation interventions. Resident #131 - Unable to correct for timeframe reviewed (10/2/18 to 10/21/18) - Plan of care was up to date to reflect resident care needs, no revisions needed. Identification of other residents: All residents have the potential to be affected by failure to ensure all treatment and care is provided in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident choices. Systematic changes and monitoring: - Medication Administration Routes/Methodology policy reflects facility accepted standard of practice and was reviewed on 11/16/18 with no changes made. - Nursing education on 11/12/18 regarding use of medication system pre-requisites which would include insulin sliding scale documentation. - Nursing education on 11/12/18 regarding facility bowel protocol and implementation of the protocol. Outcome: 95% of residents will have access to facility implemented bowel protocol as well as sliding scale documentation will be completed per professional standards of	

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F 684	Continued From page 12 (10/20/18) the resident was given Biscodyl 5 mg tablet. c. Interview with the administrative DON on 10/25/18 at 1:55 PM verified the bowel protocol was not followed; she was unsure why. Also she stated it would be reasonable to include constipation on the careplan for this resident. 2. Review of a 10/24/18 physician's order showed resident #131 had diabetes mellitus type 2. During an interview on 10/23/18 at 1:59 PM the resident stated s/he received insulin, including sliding scale insulin to manage his/her diabetes. Review of physician orders showed on 10/15/18 the physician increased the Levemir insulin to 22 units every morning. Further review of physician orders dated 9/5/18 and 9/20/18 showed the resident was to receive Novolog insulin on a sliding scale before meals. The sliding scale was: blood sugar results 201-250, give 2 units; 251-300 give 4 units; 301-350 given 6 units; 351-400 give 8 units; over 400, call physician. The following concerns were identified: a. Review of the October 2018 MAR showed insulin was documented as given before breakfast on 10/20/18, before lunch on 10/2, 10/4, 10/5, 10/6, 10/9, 10/11, 10/12, 10/14, 10/18, 10/19, 10/20, and before dinner on 10/1, 10/3, 10/4, 10/5, 10/6, 10/8, 10/9, 10/10, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19 and 10/20. However, the number of units given was not documented. b. Further review of the October 2018 MAR showed starting on 10/21/18 the number of units of Novolog given was documented. However, on 10/23/18 before supper it was documented the resident was given 1 unit of Novolog for a blood sugar of 213 and on 10/24/18 before breakfast it was documented the resident received 1 unit for	F 684	care. This data will be collected by Director of Nursing(or designee) and will be aggregated and reported monthly at long term care meetings. All discrepancies will be investigated and reported.	

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F 684	Continued From page 13 a blood sugar of 216. According to the sliding scale, 2 units should have been given for blood sugars of 201-250. c. During an interview on 10/25/18 at 1:52 PM the administrative DON stated the order for the Novolog didn't have parameters put in the system so nursing staff could document on the MAR the blood sugar results and the number of units given, but that was added at the end of October. She confirmed that since nurses were not documenting the number of units of insulin given, it could not be determined if they were following the orders regarding the sliding scale insulin.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews, and review of policy and procedures, the facility failed to ensure interventions for pain were effective for 1 of 6 sample residents (#110) reviewed for pain. The findings were: 1. Review of the 9/18/18 significant change MDS assessment showed resident #110 had frequent severe pain. The 9/28/18 care area assessment (CAA) for pain revealed the resident had chronic pain from osteoarthritis. During an interview on 10/23/18 at 4:27 PM the resident stated s/he had a lot of pain in his/her legs. Review of physician	F 697	Correction for cited residents/environment: Resident #110 Unable to correct for timeframe reviewed (10/4/18 to 10/23/18) Identification of other residents: All residents have the potential to be affected by failure to ensure post-administration evaluation are completed to determine effectiveness of a PRN medication. Systematic changes and monitoring:	12/9/18

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F 697	Continued From page 14 orders showed the resident was ordered oxycontin 10 mg every 12 hours routinely, and also oxycodone HCL 5 mg every four hours as needed. The following concerns were noted: a. Review of the October 2018 MAR showed the resident received the PRN oxycodone on 10/4/18, 10/6/18, 10/7/18, 10/9/18, 10/11/18, 10/13/18, 10/15/18 (twice), 10/17/18, 10/19/18 (twice), and 10/23/18. Further review of the MAR showed no post-administration evaluation to determine effectiveness of the PRN medication. Review of the medical record showed no documentation of effectiveness of the PRN pain medication b. During an interview on 10/25/18 at 9:54 AM the administrative DON confirmed there was no documentation to show the effectiveness of the PRN pain medication. She stated the medication profile was not set up in the computer system to prompt nursing staff to complete a post-administration assessment. 2. Review of the facility's policy "Pain Management"(reviewed/approved June 13, 2017) showed "...Patients' response to intervention will be assessed as follows: i. Report of current pain intensity ii. Within 30 minutes following IV, IM, or SQ pain medication administration or Non-pharmacologic intervention. iii. Within 60 minutes following PO pain medication administration."	F 697	- Nursing education on 11/12/18 regarding appropriate medication follow up per facility policy as well as professional standards of care. - Pain Management policy reflects facility accepted standard of practice. Policy was reviewed on 11/16/18 with no changes made. Outcome: 95% of resident will have appropriate medication follow up per facility policy as well as professional standards of care. This data will be collected by the Director of Nursing (or designee) and will be aggregated and reported monthly at long term care quality meetings. All discrepancies will be investigated and reported.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		12/9/18

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F 755	Continued From page 15 §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 review of medication error reports and staff interviews, the facility failed to develop an effective system for reducing pharmacy dispensing, packaging, and profiling errors for 12 residents (#5, #14, #17, #58, #68, #92, #102, #116, #119, #138, #197, #298). The facility census was 151. The findings were: 1. Review of the 8/1/18 to 10/24/18 medication error reports showed pharmacy errors resulted in	F 755	Correction for cited residents/environment: Resident #5: - Unable to correct for profiling error for cited resident, pharmacist inadvertently discontinued the order. This error reached the resident for 7 days until corrected. Resident #14: - Identified by nursing staff on 10/16/18 as packaging error, replacement doses	

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F 755	Continued From page 16 delayed or missed medications for residents. In addition, further review showed increased risk of errors in medication administration due to pharmacy profiling, dispensing, and packaging errors. The following concerns were identified during review of the error reports: a. On 8/8/18, carvedilol (beta blocker) was ordered for resident #58. The physician ordered the medication to be held for systolic blood pressure less than 100 and heart rate less than 50. The pharmacy profile incorrectly replaced the word "and" for "or" and the parameters were changed to "hold for systolic blood pressure less than 100 or heart rate less than 50." b. PRN and scheduled oxycodone (pain medication) were ordered for Resident #17, until 8/8/16 when the physician's orders directed staff to discontinue the scheduled oxycodone. The pharmacy discontinued both the scheduled and PRN doses. This error resulted in a delayed response to the resident's request for PRN pain medication. c. On 8/13/18, Spiriva (bronchodilator) for resident #5 was discontinued by the pharmacy without an order. d. On 8/27/18, resident #102's fluticasone (corticosteroid) nasal spray was discontinued by the pharmacy without an order. e. On 8/30/18, escitalopram (anti-depressant) ordered for resident #138 was discontinued by the pharmacy without an order. f. On 9/6/18 oral cortisone was ordered for resident #116 to be given at bedtime. The pharmacy was notified of the order before 4 PM that day; however, the medication was not delivered until 3 AM on 9/7/18. g. On 10/23/18 the physician's orders for resident #197 directed staff to use the peripherally inserted central catheter access	F 755	ordered to complete physician ordered dosing. Pharmacy supplied replacement doses, no error reached the resident. Resident #17: - Unable to correct for profiling error for cited resident, pharmacist inadvertently discontinued the order. This error did not reach the resident. Resident #58: - Unable to correct profiling error for cited resident as pharmacy profiled medication as "or" and the order was later clarified as "and." The error did reach the resident. Resident #68: - Identified by nursing staff on 10/16/18 as packaging error, replacement doses ordered to complete physician ordered dosing. Pharmacy supplied replacement doses, no error reached the resident. Resident #92: - Identified by nursing staff on 10/15/18 as packaging error, replacement doses ordered to complete physician ordered dosing. Pharmacy supplied replacement doses, no error reached the resident. Resident #102: - Unable to correct for profiling error for cited resident, pharmacist inadvertently discontinued the order. This error reached the resident for 20 days until identified and corrected. Resident #116: - Unable to correct medication availability due to taxi service. Pharmacy nor nursing could find the medication location as it was later found at 0300 in the center counsel of taxi vehicle. Error did reach the resident as it was a delay in administration.	

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F 755	Continued From page 17 (PICC) for administration of the scheduled intravenous antibiotic. This order also directed staff to discontinue an additional second infusion line. The pharmacy staff discontinued the intravenous medication, and the resident missed one of the scheduled doses. h. Calcium citrate two 250 milligrams tablets per dose was ordered for resident #68. The dispensed medication bubble pack for October 2018 contained only one 250 milligram tablet per dose. i. Two vitamin D3 tablets per dose were ordered for resident #14. The dispensed medication bubble pack for October 2018, contained only 1 tablet per dose. j. Some of the daily doses of famotidine (antacid and anti-histamine) 20 mg were missing in the October 2018 medication bubble pack for resident #92. k. On 10/13/18 resident #119 received a delayed dose of Cefuroxime 500 mg (antibiotic) because the medication was not available in the automatic medication dispensing machine. l. On 10/23/18 the pharmacy profile for resident #298 included Meloxicam 15 mg instead of the ordered 7.5 mg dose. m. From 9/14/18 to 10/23/18 the pharmacy staff dispensed bags of saline flush identified as heparin flush, Lisinopril 10 mg instead of 5 mg as ordered, Metoprolol 25 mg instead of 12.5 mg as ordered and Levothyroxine 75 micrograms instead of 50 micrograms as ordered. During the same time period, Carvedilol 12.5 mg and Carvidopa/levidopa 25/100 mg were put in the same pocket in the automatic medication dispensing machine; and packages of Cefuroxime were dispensed without dose labels . 2. On 10/24/18 at 9:30 AM, interview with the	F 755	Resident #119: - Unable to correct medication availability in automated machine at time of order, resident did receive full dosing per providers orders delayed by 24 hours. Resident #138: - Unable to correct for profiling error for cited resident, pharmacist inadvertently discontinued the order. This error did not reach the resident. Resident #197: - Unable to correct for profiling error for cited resident, pharmacist inadvertently discontinued the order. This error did reach the resident as two doses were omitted from plan of care. Resident #298: - Unable to correct, resident did receive one dose of incorrect medication as it relate to pharmacy profiling and dispensing. Nursing did not identify error until after one dose was administered. Identification of other residents: All residents have the potential to be affected by dispensing, packaging, and profiling errors. Systematic changes and monitoring: - Site visit on 12/15/18 to review process in which pharmacy and nursing interact with profiling medications. - Site visit on 11/29/18 to review med dispense machines and ensure medications are packaged appropriately, in correct storage bins, and are not expired. - Continuation of reporting errors timely as well as pharmacy response, process not	

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F 755	Continued From page 18 administrative DON revealed the facility had been working with the pharmacists to address the problems, but the number of incidents had not decreased. 3. On 10/25/18 at 9:00 AM interview with the director of pharmacy services revealed he was aware of the dispensing and profiling problems, and changes in processes and procedures were being developed. He further stated the recently hired new pharmacist had some technological problems with packaging; the pharmacy staff needed additional education; and the pharmacists and nursing staff needed to develop an effective method for communicating medication start and stop dates.	F 755	to exceed 14 days per policy titled "Incident Reports - Patient Safety Reports" utilizing quality improvement principles. - Monthly report from pharmacy regarding dispensing, packaging, and profiling errors as well as process put in place to eliminate ongoing errors from occurring utilizing quality improvement principles. -Geneva Woods staff education on 11/19/18 regarding the following: medication profiling, taxi use for medication courier when using back up medication sites, clarifying orders as appropriate, packing of medications, monitoring par levels in med dispense, and dispensing proper medication. Outcome: Decrease amount of pharmacy related dispensing, packaging, and profiling errors by 40%. Total number of errors will be collected by Director of Nursing (or designee) and will be aggregated and reported monthly at long term care quality meetings. All discrepancies will be investigated and reported.	
F 812 SS=D	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	F 812		12/9/18

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F 812	Continued From page 19 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 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, staff interview, and review of policy and procedures, the facility failed to ensure hand hygiene was completed as required and that hand-washing sinks were accessible in 2 of 3 kitchens observed (Pine Place Unit, Aspen/Rehabilitation Unit). The findings were: 1. Observation on 10/24/18 at 11:27 AM of the Aspen/Rehabilitation Unit showed the following concerns: a. At 11:38 AM server #1 had been preparing plates of food for residents when she stopped to make a phone call. After handling the phone, the server failed to perform hand-washing and proceeded to prepare plates of food for the residents. b. During the observation from 11:27 AM to 11:38 AM the hand-washing sink located on the back wall of the kitchen was obstructed with a tray of dirty dishes. Additionally, there were soiled utensils located in the sink. 2. Observation on 10/24/18 at 11:44 AM of the Pine Place Unit kitchen showed the following concerns: a. The hand-washing sink located on the	F 812	Correction for cited residents/environment: Server #1: -On the spot education regarding hand hygiene provided to food service worker on 10/24/18. Server #2: -On the spot education regarding hand hygiene provided to food service worker on 10/24/18. Aspen/Rehab Community Kitchen Sink: - On the spot education regarding not blocking hand washing sink provided to the food service worker on 10/24/18. Pine Place Community Kitchen Sink: - On the spot education regarding not blocking hand washing sink provided to the food service worker on 10/24/18. Identification of other residents: All residents have the potential to be affected by not completing appropriate hand hygiene during the food serving process as well as lack of access to hand washing sinks.	

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F 812	Continued From page 20 back wall of the kitchen was covered with lids which had been removed from the steam-table pans. b. At 11:47 AM server #2 prepared a plate of food for a resident, covered it with a lid and delivered it to the resident's room. When the server returned to the kitchen she failed to wash her hands and proceeded to prepare plates of food. Additionally, at 11:55 AM the server returned to the kitchen from delivering a room tray and used hand gel in place of washing her hands. 3. Interview with the dietary manager and nutrition services supervisor on 10/24/18 at 3:42 PM verified hand-washing was to be performed when hands were contaminated and when returning to the kitchen. They further stated the sinks needed to be kept accessible. 4. Review of the 8/3/18 policy and procedure titled "Safe Food Handling Handout" showed "...When preparing food you should have access to proper hand washing facilities...Antimicrobial gel (hand hygiene agent that does not require water), cannot be used in place of proper hand washing techniques in food handling." 5. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of	F 812	Systematic changes and monitoring: - Removal of hand sanitizer containers in community kitchens on 11/9/18. - Review of facility policy title "Safe Food Handling Handout" and no changes were identified. - Education on hand hygiene for food service workers at facility all staff meeting on 11/8/18. - Education on hand hygiene for food services workers at nutrition department meeting to be completed on 11/30/18. - Signs placed at community kitchen hand washing sinks to indicate that the sink is only for hand washing purposes on 11/8/18. Outcome: 100% of staff will demonstrate proper hand washing techniques during the food procurement, preparation, and service stage of the meal serving process. This data will be collected by the nutrition supervisor (or designee) and will be aggregated and reported monthly at long term care quality meetings. All discrepancies will be investigated and reported.	

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THE LEGACY LIVING AND REHABILITATION CENTER	1000 S DOUGLAS HWY GILLETTE, WY 82716

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F 812	Continued From page 21 arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands." 6. According to Food Code 2017, U.S. Public Health Service: 5-205.11 "(A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use. (B) A HANDWASHING SINK may not be used for purposes other than handwashing."	F 812		