STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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 1/28/19 to 1/31/19. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide CPR- Cardiopulmonary resuscitation DON- Director of Nursing LPN- Licensed Practical Nurse mg- milligrams Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		2/1/19

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

Electronically Signed | 02/18/2019

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policies, the facility failed to ensure accurate advance directive information was available to staff for 3 of 16 sample residents (#1, #9, #22). The findings were: 1. Review of the medical record for resident #1 showed an advance directive dated 1/18/18 for no life prolonging measures (no CPR). The following concerns were identified: a. Observation on 1/29/19 at 2:43 PM showed a green star outside of the resident's door, indicating the resident desired a full code (CPR would be initiated). b. Review of the CNA and nurse shift change report forms showed the resident was listed as	F 578	Resident #1 All paperwork in chart reviewed by DON, most recent code status dated 1/29/2019 stating resident is a DNR. DON confirmed this status with resident and POA. Star changed outside of residents room to reflect DNR status (red star), copy of DNR placed in residents room on cork board upside down. CNA and Charge nurse report sheets changed to reflect the DNR status. This was completed on 2/1/19 Resident #9 Chart reviewed by DON, resident is a DNR. Star outside of residents room changed to reflect DNR status (red star) and copy of DNR placed in residents	

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F 578	Continued From page 2 "CPR." c. During an interview on 1/30/19 at 5:26 PM the DON stated the resident had a do-not-resuscitate (DNR) advanced directive, so the green star outside the room and the shift change forms for staff were wrong. 2. Review of the medical record for resident #9 revealed an advance directive dated 10/31/18 which indicated the resident did not want life prolonging treatment (no CPR). Review of the CNA and nurse shift change report forms also indicated the resident had selected DNR. The following concerns were identified: a. Observation on 1/29/19 at 2:51 PM showed a green star outside of the resident's room, indicating CPR should be initiated. b. On 1/30/19 at 5:24 PM the DON stated the green star outside of the resident's room was wrong. 3. Review of the medical record for resident #22 showed admission orders dated 6/27/18 which indicated the resident's resuscitation status was "CPR." The following concerns were identified: a. Observation on 1/29/19 at 2:43 PM revealed a red star outside of the resident's room, indicating the resident had selected DNR. b. Review of the CNA and nurse shift change report forms showed the resident was listed as DNR. c. During an interview on 1/30/19 at 6:12 PM the DON stated she spoke with the physician, who said when he admitted the resident, s/he told him s/he wanted CPR. The DON stated the resident had an advance directive for DNR, so she was going to call the family to clarify the resident's status. d. Review of the advance directive dated	F 578	room on cork board upside down. CNA and Charge nurse report sheets changed to reflect the DNR status. This was completed by 2/1/19 Resident #22 Chart reviewed by DON. Residents family called to confirm code status. Clarification order wrote for a DNR status, physician notified. Star changed to reflect DNR status (red star) and copy of DNR placed in residents room on cork board upside down. CNA and Charge nurse report sheets changed to reflect the DNR status. This was completed on 2/1/19 All facility residents are at risk, to protect our residents and prevent this from happening to any other residents, SLNC will: 1. All 23 residents charts were reviewed to ensure that their code status from the chart matched the stars outside their rooms and a copy of the code status was placed on each residents cork board turned upside down. This was completed on 2/1/2019 2. All SLNC staff were educated on where to find the code status (i.e star outside door and on cork board) in a staff meeting on 2/14/2019. 3. DON or Social Services Designee will monitor each residents code status on a monthly basis, beginning the month of February and will be monthly thereafter. Results	

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F 578	Continued From page 3 7/16/03 showed the resident did not want dying to be artificially prolonged. e. On 1/31/19 at 8:53 AM the DON stated the family verified the resident's resuscitation status was DNR, so the physician wrote a new order. 4. During an interview on 1/31/19 at 8:53 AM the DON stated resident CPR status information was in a couple of places; stars outside of the residents' rooms, the shift change reports, and in the medical record. She confirmed the information did not always match up. She stated the goal was to have a copy of the advance directive posted backwards on the board in each resident's room, so it could be verified during a code blue. Review of the facility's policies "Code Blue" (undated) and "Advance Directives" (undated) showed neither policy addressed how code status should be verified by staff.	F 578	will be tracked on our QA/QI log. 4. Any concerns will be reported to the QA/QI committee in the monthly meetings.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the environment was free of safety hazards for 1 of 16 sample residents (#12). The findings were: 1. Observations on 1/29/19 at 10:40 AM, and	F 689	Resident #12 DON and Maintenance met to review residents walker and oxygen situation. Maintenance ordered a bracket to secure the oxygen bottle to residents walker without affecting her ambulation. Bracket	2/28/19

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F 689	Continued From page 4 1/30/19 at 9:04 AM and 5:50 PM revealed resident #12 utilized a walker for ambulation and also utilized supplemental oxygen. Further observation showed a portable oxygen tank was placed on top of the walker, between the handles of the walker and the frame of the walker. The oxygen tank was not secured. 2. Interview with the DON on 1/31/19 at 8:50 AM revealed the facility had tried oxygen tank bags for the resident's walker in the past, but it "threw the resident off; wasn't able to manage walker." She confirmed the oxygen tank was resting on the top of the walker and wasn't secured, and stated "it's not the safest."	F 689	was ordered on 1/29/2019 and placed on walker week of 2/4/2019. All facility residents are at risk, to protect our residents and prevent this from happening to any other residents, SLNC have/will: 1. Educate all staff members on safety concerns for residents with oxygen needs. This was done on 2/14/2019. 2. DON or designee have created a QA/QI project to review safety concerns with oxygen, wheelchairs, walkers, geri-chairs on a monthly basis x 3 months then quarterly. Results will be tracked on our QA/QI log. 3. DON identified two more safety concerns and has talked with maintenance to order more brackets to secure oxygen tank to another walker and geri-chair. This will be completed by 2/28/2019. 4. Any concerns will be reported to the QA/QI committee in the monthly meetings.	
F 755 SS=D	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 §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.	F 755		2/28/19

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F 755	Continued From page 5 §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, staff interview, and review of facility policy, the facility failed to ensure medications for resident use were not expired in 1 of 2 medication storage areas (medication cart). The findings were: 1. Observation of the medication cart on 1/30/19 at 9:42 AM showed one Levemir (insulin) 100 unit/milliliter flex touch pen expired 12/29/18. In addition one sleeve of tramadol (pain reliever) HCL 50 mg tablets expired 12/18. Interview at that time with LPN #1 confirmed the medications were expired and were for resident use. 2. Interview with DON on 1/30/19 at 1:25 PM	F 755	Consulting Pharmacist present at facility on 1/29/2019 and all expired medications were removed from the medication cart the day they were found. All facility residents are at risk, to protect our residents and prevent this from happening to any other residents, SLNC have/will: 1. DON spoke with consulting pharmacist and the monthly review sheet was changed to include all areas that medications are kept. 2. DON and Consulting Pharmacist will be	

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F 755	Continued From page 6 revealed it was the expectation of the facility for all medication to be checked monthly for expirations, and removed if outdated. 3. Review of the policy titled "Expired Medications" dated 1/10/18 showed "...It is the policy of South Lincoln Nursing Center to ensure that residents do not receive outdated medications."	F 755	tracking all expired medications on a monthly basis starting the month of February. Each month the number of expired medications will be tracked on the QA/QI log. 3. SLNC is currently in the process of ordering stickers for the insulin pens that have a place for when the pen was removed from the fridge and when it will expire. This will improve our current process of writing on them with markers that rub off. This will be completed by 2/28/2019. 4. Any concerns will be reported to the QA/QI committee in the monthly meeting.	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility documentation, the facility failed to ensure therapeutic diet orders were followed for 1 of 3 sample residents (#4) reviewed for diet orders. The findings were: 1. Observation on 1/28/19 at 5:55 PM showed resident #4 was assisted with the evening meal.	F 808	Resident #4 DON reviewed residents diet order and found an order for full liquid. DON talked with primary care provider and order reviewed and added to have mashed potatoes daily if requested by resident. This was completed on 1/30/2019 All facility residents are at risk, to protect	2/4/19

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F 808	Continued From page 7 The resident was served a bowl of mashed potatoes with brown gravy. Observation of the diet card at that time showed "Full Liquids." Observation on 1/29/19 at 6:20 PM showed resident #4 was served mashed potatoes with brown gravy. The following concerns were identified: a. Review of the physician's orders showed an order for full liquid diet dated 11/30/18. b. Observation in the kitchen on 1/30/19 at 10:55 AM showed the diet card for the resident read "Full Liquids." Interview at that time with the certified dietary manager (CDM) revealed the resident was on a full liquid diet. She stated the resident received juice, Boost, soups, pudding, cream of wheat and mashed potatoes. The CDM provided a one page sheet which listed foods that were acceptable for a full liquid diet. Review of the information showed mashed potatoes was not included in the list. c. Interview with the registered dietitian on 1/30/19 at 3:15 PM revealed mashed potatoes was not an appropriate food for a full liquid diet. He confirmed the resident should not have been served the mashed potatoes and gravy without a physician's order.	F 808	our residents and prevent this from happening to any other residents, SLNC have/will: 1. All SLNC staff provided with education on 2/14/19 that dietary will only be providing what is ordered by the physicians for our residents. This will take place immediately. 2. Dietary manager and DON reviewed all residents current dietary orders and six other residents found that needed orders wrote to be compliant with this federal tag. All six residents physicians were contacted and new orders received. This was completed on 2/14/19. 3. DON or Dietary Manager will continue to monitor diet orders for all residents against what residents are receiving at meals. This will be a monthly QA/QI project and tracked on our QA/QI log. 4. Any concerns will be reported to the QA/QI committee in the monthly meetings.	