STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 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 3/24/19 through 3/27/19. Also reviewed in the course of the survey was complaint intake WY00002799. The following common abbreviations are used throughout this document. BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant CNO: Chief Nursing Officer DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		5/11/19

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

Electronically Signed | 04/18/2019

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F 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes and resident and staff interview, the facility failed to ensure grievances from the resident council were acted upon and followed through to resolution for 3 of 3 months reviewed (January 2019, February 2019, March 2019). The findings were: 1. Review of the resident council minutes for January 2019, February 2019, and March 2019 showed concerns with the dietary, nursing, and housekeeping departments. The following concerns were identified: a. Review of the January 2019 resident council minutes showed 3 concerns related to dietary and 5 concerns related to nursing. The concern in regard to staffing from 2 PM through supper showed a follow-up of "In-service staff". The follow-up section to the remaining 7	F 565	This requirement will be met as evidenced by: A.) All Grievances identified in the monthly Resident Council meeting minutes from January, February and March will be updated with a follow-up/resolution in the meeting minutes from each department involved in the grievance. At the May Resident Council meeting those grievances and follow-up/resolutions will be presented to the residents. Going forward, any grievances voiced in resident council will be addressed by the respective department and a follow-up/resolution will be added to the minutes and presented to the residents at the next Resident Council meeting. This will be implemented by	

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F 565	Continued From page 2 concerns was left blank. b. Review of the February 2019 resident council minutes showed 2 concerns related to nursing and 2 concerns related to housekeeping. The 2 nursing concerns were in regard to call lights and waiting for assistance from staff; the follow-up section was left blank. One housekeeping concern about "missing blankets" showed a follow-up of "In-service staff." The additional housekeeping concern identified had a follow-up section that was left blank. c. Review of the March 2019 resident council minutes showed 3 nursing concerns related to call light response time and the manner in which staff communicated when they responded. The follow-up to these concerns was marked as "In-service." 2. Interview with 11 residents on 3/25/19 at 1:30 PM revealed they were told the issues had been addressed; however the identified nursing concerns continued to occur. 3. Interview with the social service director on 3/25/19 at 2:13 PM revealed the concerns identified at the resident council meeting were given to the appropriate department for resolution. She stated the nursing department was then educated at their monthly staff meeting. In addition the resident council minutes used to include the resolution of the concerns; however she thought that was no longer a requirement. 4. Interview with the DON on 3/27/19 at 12:03 PM revealed she educated staff in regard to the identified concerns, but had not investigated them. In addition she stated she had not attended a resident council meeting since becoming the DON in February of 2019.	F 565	May 11, 2019. B.) Department heads will be educated on the necessity to provide feedback for the residents about their grievances brought up at resident council meetings. C.) Meeting minutes will be updated to include follow-up/resolution reports from each respective department to ensure these grievances are being addressed and handled appropriately. D.) Meeting minutes will be audited by the Director of Social Services monthly and reported on quarterly at the QAPI meeting for one year to ensure all grievances are being handled appropriately and timely.	

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F 575 SS=B	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the mailing and email addresses of all pertinent State agencies and advocacy groups and include a statement that the resident may file a complaint with the State Survey Agency. The census was 29. The findings were: Observation of the information board located in the main area of the facility during the survey timeframe showed the posting failed to include the mailing and email addresses of all pertinent	F 575	This requirement will be met as evidenced by: A.) The Information Board will be updated with pertinent addresses, emails and phone numbers for all State Agencies and Advocacy Groups. A statement notifying residents of their right to file a complaint with the State Survey Agency will be posted in the same area along with the grievance forms. This will be completed by May 1, 2019. B.) The Information Board log will be	5/1/19

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F 575	Continued From page 4 State agencies and advocacy groups. In addition the posting failed to include the required statement pertaining to the resident's right to file a complaint with the State Survey Agency. Interview with the social service director on 3/26/19 at 5 PM revealed she was unaware of the information that must be included in the required posting.	F 575	updated annually or upon notification of change to include addresses and emails for each pertinent State Agencies and Advocacy groups. A statement of the resident□s right to file a complaint will be posted next to the grievance forms to ensure all information is correct and accessible and so each resident is aware of their right to file grievances as well as the process to do so. C.) The updates to the information board will be completed by the Director of Social Services. These will be checked quarterly for accuracy and updated.	
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. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		5/11/19

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F 578	Continued From page 5 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 medical record review and staff interview, the facility failed to ensure residents' advance directive preferences were accurately documented in the electronic medical record for 4 of 16 sample residents (#10, #23, #26, #81) reviewed. The findings were: 1. Review of the advance directive for resident #10 showed the resident's preference was DNR (do not resuscitate); no nutrition or hydration by intravenous line; and chose to have pain medication, a blood transfusion, and transfer to the hospital if appropriate. Review of the resident's face sheet on the EMR (electronic medical record) showed the resident's preference was "Full Code." 2. Review of the advance directive for resident #23 showed the resident's preference was DNR;	F 578	This requirement will be met as evidenced by: A.) Advanced Directives for Residents (#10,#23,#26, #81) will be updated in the EMR(electronic medical record) and on the demographic sheet. All resident Advanced Directives will be reviewed and revised to make sure they are in compliance. This was completed on 5/11/2019. B.) RN/LPN□s will be educated on proper placement in the EMR for Advanced directives C.) A Monitoring tool will be developed in order to ensure that the EMR and face sheets are being updated as they are admitted. This will be completed by 5/11/2019. D.) The Monitoring tool will be completed	

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F 578	Continued From page 6 chose not to have hydration or nutrition by feeding tube or intravenous line; and chose to have pain medication, a blood transfusion and transfer to the hospital if appropriate. Review of the resident's face sheet on the EMR showed the resident's preference was "Full Code." 3. Review of the advance directive for resident #26 showed the resident's preference was DNR; no nutrition or hydration by intravenous line; and chose to have pain medication, a blood transfusion, and transfer to the hospital if appropriate. Review of the resident's face sheet on the EMR showed the resident's preference was "Full Code." 4. Review of the advance directive for resident #81 showed the resident's preference was DNR; no nutrition or hydration by intravenous line; and chose to have pain medication, a blood transfusion, and transfer to the hospital if appropriate. Review of the resident's face sheet on the EMR showed the resident's preference was "Full Code." 5. Interview with the DON on 3/26/19 at 9:34 AM confirmed the EMR had not been updated to reflect the resident's advance directive preferences.	F 578	by Social Services upon admission and reported on quarterly at the facility QAPI meeting for the duration of a year.	
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		5/1/19

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F 585	Continued From page 7	F 585		

respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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F 585	Continued From page 8	F 585		

program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 9 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure the grievance policy contained all required information. The census was 29. The findings were: 1. Observation of the facility during the survey timeframe showed "Resident/Family Grievance" forms were located next to the information board in the main area of the facility. However, the grievance policy and contact information for the grievance official were not posted. 2. Review of the policy and procedure entitled "Resident Grievance Policy" last revised 4/25/16 showed the policy failed to contain required information including the contact information of the grievance official and the contact information of independent entities with whom a grievance could also be filed. Further, the policy did not address the residents' right to file a grievance anonymously. 3. Interview with the social service director on 3/26/19 at 5 PM verified the policy did not contain the required information and the residents had not been informed individually or through postings.	F 585	This requirement will be met as evidenced by: A.) The Grievance Policy and contact information for the Grievance Official will be updated to include contact information for the grievance official as well as any independent entities with whom a grievance could also be filed. The policy and procedure for submitting a grievance will be posted next to the grievance forms by the information board by May 1, 2019. B.) Grievance policy will be reviewed annually for compliance as well as upon any change of Grievance Official or reporting entities. C.) Compliance officer will review policies annually, upon which any changes will be updated and distributed to residents as well as posted by the information board. D.) Any substantial changes to policy and or any grievance official and/or reporting entities will be updated at the time of occurrence and will be distributed to residents as well as posted by the information board.	
F 623	Notice Requirements Before Transfer/Discharge	F 623		5/11/19

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F 623 SS=D	Continued From page 10 CFR(s): 483.15(c)(3)-(6)(8)	F 623		

§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,

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F 623	Continued From page 11 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (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.	F 623		

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F 623	Continued From page 12 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued for 2 of 2 residents with facility-initiated transfers (#4, #27). The findings were: 1. Review of the medical record for resident #4 showed s/he was admitted to the hospital for an acute change of condition on 2/26/19 and was readmitted to the facility on 2/28/19. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record for resident #27 showed s/he was admitted to the hospital for an acute change of condition on 3/19/19 and remained hospitalized at the end of the survey on 3/27/19. Further review showed no evidence the facility issued a written notice of transfer to the	F 623	This requirement will be met as evidenced by: A.) All residents will be transferred to other facilities in compliance with the Nursing Home notice of transfer and discharge requirement to include the transfer notice given to the resident. Resident medical records for #4 and #27 will be reviewed and assessed. The Transfer policy has been developed and transfer notices are in the process of being created for our EMR. This process will be completed by May 11, 2019. B.) RN/LPN□s will be educated on the process of transferring residents to other facilities in compliance with the Nursing Home notice of transfer and discharge requirement.	

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	535019	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 623	Continued From page 13 resident or the resident's representative. 3. Interview with the DON on 3/26/19 at 9:49 AM verified transfer notices had not been issued to the resident or the resident's representative. Further, she stated a policy had recently been developed, however it had not been implemented.	F 623	C.) Social Services will create monitoring tool will be developed in order to ensure that all transfers are given appropriate written notice when transferred out of the facility. The transfer policy will be reviewed annually for compliance as well as upon any changes to state or federal requirements. D.) Social Services will monitor transfers and notices given to residents for compliance with CMS regulations on a monthly basis and reported on quarterly at the QAPI meeting for the duration of a year.	
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 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)	F 625		5/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 14 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 notice of the bed-hold policy was issued for 2 of 2 residents with facility-initiated transfers (#4, #27). The findings were: 1. Review of the medical record for resident #4 showed s/he was admitted to the hospital for an acute change of condition on 2/26/19 and was readmitted to the facility on 2/28/19. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 2. Review of the medical record for resident #27 showed s/he was admitted to the hospital for an acute change of condition on 3/19/19 and remained hospitalized at the end of the survey on 3/27/19. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 3. Interview with the DON on 3/26/19 at 9:49 AM verified the written notice of the bed-hold policy had not been issued to the resident or the resident's representative. Further, she stated a policy had recently been developed, however it	F 625	This requirement will be met as evidenced by: A.) All residents when transferred out of the facility will be presented with a notice of the Bed Hold. Residents (#4, #27) will be reviewed and assessed. The Notice of Bed Hold has been developed and will be in operation by May 11, 2019. B.) All transfers for the past 3 months will be reviewed for notice of Bed Hold. C.) RN/LPN□s will be educated on presenting each resident who are being transferred with a Bed Hold notice. D.) Bed Hold notice will be reviewed annually for compliance as well as upon any changes to state or federal requirements. Social Services will be responsible for monitoring that all transfers receive a Bed Hold Notice upon discharge. E.) Social Services will monitor monthly for compliance with CMS regulations. This will be reported on quarterly at the	

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F 625	Continued From page 15 had not been implemented.	F 625	QAPI meeting for the duration of a year.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 2 of 16 sample residents (#1, #26). The findings were: 1. Observation on 3/25/19 at 9:44 AM showed 1/2 side rails on both sides of the bed for resident #1. Review of the quarterly MDS assessment dated 3/11/19 showed the side rails were used as a restraint. The following concerns were identified: a. Interview on 3/26/19 at 9:33 AM with LPN #1 revealed the resident had never been in restraints and the side rails were used for repositioning. b. Interview on 3/26/19 at 2:48 PM with the DON revealed the side rails were used for repositioning and not as a restraint. She further stated she was not sure where to document the side rails on the MDS. 2. Review of the 2/4/19 quarterly MDS assessment showed resident #26 had no falls since the prior assessment completed on 11/12/18. The following concerns were identified: a. Review of a Post Fall Assessment and Intervention form dated 11/22/18 showed the	F 641	This requirement will be met as evidenced by: A.) All resident restraint and post fall assessments will be reviewed and updated in MDS and EMR by RN/LPN. Restraint and post fall assessments for residents #1 and #26 will be reviewed and revised and modified in the MDS to show current status of restraints and post fall assessment. Resident #1and #26 will be reviewed and revised by May 11, 2019. B.) DON will be educated on how to properly report restraints on MDS. CNO will perform the education. C.) DON will create monitoring tool to reflect assessment of restraint and post fall occurrences to ensure that they are correctly entered into the MDS. D.) DON will complete Monitoring tool monthly and report quarterly at QAPI meeting for the next year.	5/11/19

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F 641	Continued From page 16 resident had an unwitnessed fall on 11/21/18. b. Interview with the DON on 3/26/19 at 4:52 PM revealed an incident report had not been completed after the fall and submitted to administration, and as a result the fall was not recognized and recorded on the MDS assessment. According to the MDS 3.0 RAI Manual version 1.15, page 395: Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury. According to the MDS 3.0 RAI Manual version 1.15, page 531: Section P: Restraints and Alarms: "...the intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used at any time during the day or night during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories..."	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		5/11/19

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F 657	Continued From page 17 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, family and staff interview, the facility failed to ensure the individualized person-centered care plan was revised as needed to reflect the resident's current needs for 5 of 16 sample residents (#1, #14, #15, #23, #26). The findings were: 1. Review of the medical record showed resident #1 was admitted on 6/29/18 with diagnoses that included hypertension, reflux disease, osteoporosis, asthma, and borderline personality disorder. Observation on 3/25/19 at 9:44 AM showed the resident was resting in bed. Interview with the resident at that time revealed s/he did not get out of bed due to arthritis and pain. S/he further stated s/he was not receiving therapy. The	F 657	This requirement will be met as evidenced by: A.) All resident care plans will be reviewed and updated in MDS and Wincare by RN/LPN. Care plans will correctly reflect plan of care for each individual resident. Care plans for residents (#1, #14, #15, #23, #26) will be reviewed and revised by May 11, 2019. B.) DON will identify and review all other resident care plans for accuracy. C.) RN□s will be educated on care planning by the DON.	

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F 657	Continued From page 18 following concerns were identified: a. Review of physical therapy notes dated 2/26/19 showed the resident became agitated and refused care when they saw her/him. b. Interview on 3/26/19 at 3:03 PM with LPN #1 revealed the resident refused to get of out bed and refused to move his/her legs and left arm. She added the resident refused repositioning. c. Review of the MDS showed a quarterly assessment was completed on 3/11/19. Review of the care plan showed a review date of 11/14/19; 4 months prior to latest quarterly assessment. Further review of the care plan failed to show interventions to address the resident's pain. 2. Review of the medical record showed resident #14 was admitted on 5/5/15 with diagnoses which included cervicalgia, chronic obstructive pulmonary disease, and epilepsy. The following concerns were identified: a. Interview on 3/25/19 at 11:36 AM with the resident's brother revealed the resident had constant pain in his/her neck and was unable to take the bus because it hurt too much. The facility was going to get a special pillow to support the resident's neck. He further stated s/he had a hearing aid that caused pain, and he thought the facility was going to fix it but was not sure. b. Review of the MDS showed a quarterly assessment was completed on 3/4/19. Further review showed the resident had a pain level of 5 on a scale of 10 (with 1 being the least pain and 10 being the most), and received as needed pain medication, the resident also had a hearing aid. c. Review of the care plan showed it was last reviewed 12/17/18, and failed to show interventions that would help decrease the pain, and what made the pain worse.	F 657	D.) DON will create a monitoring tool that will accurately reflect the review of each care plan. This will be monitored monthly and reported quarterly at QAPI meeting for the duration of a year.	

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F 657	Continued From page 19	F 657		

d. Review of the Care Plan Meeting Summary dated 3/4/19 showed the facility purchased a neck pillow to ease some of the vehicle motion. Review of the care plan failed to show this intervention.

e. Interview with LPN #1 on 3/26/19 at 3:53 PM revealed the resident had a hearing aid which caused him/her pain. She stated the facility had it fitted to the ear, and had cleaned the ear, but the resident could only wear it for a couple days before s/he complained of pain. Review of the care plan failed to have a plan for the hearing aid.

3. Review of the medical record showed resident #15 was admitted on 8/10/18 with diagnoses which included dementia. On 3/25/19 multiple observations from 8:00 AM to 4:00 PM showed the resident wandered throughout facility holding a doll. Continued observations showed staff redirected the resident to the common area and included him/her in the activities. Interview on 3/26/19 at 11:30 AM with LPN #1 revealed the resident wandered but had not tried to walk out the door. She added they tried to place a wander guard multiple times but the resident removed it. When staff saw the resident walk towards the hospital they walked with the resident and redirected him/her. She further stated staff sat with the resident during meals and encouraged him/her to eat. The following concerns were identified:

a. Review of the MDS showed a quarterly assessment was completed on 2/4/19.

b. Review of the care plan showed the last review date was 11/29/18. Further review of the care plan showed wander alarm check every shift, and failed to show interventions used when resident removed the wander guard.

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F 657	Continued From page 20	F 657		

4. Review of the medical record showed resident #23 was admitted on 1/14/19 with diagnoses which included diabetes, hypertension and heart failure. Observation on 3/25/19 at 3:29 PM showed the resident had an ace wrap dressing and heel protector to the right lower leg. Interview with the resident at this time revealed s/he had pressure ulcer on his/her heel and was seeing a physician who managed the wound. Review of the care plan with a review date of 1/18/19 failed to show evidence of a wound. Interview on 3/26/19 at 10 AM with the DON revealed the care plan was not revised to reflect the wound and wound care.

5. Review of the 2/4/19 MDS assessment showed resident #26 was admitted to the facility on 10/31/18 and had diagnoses which included anemia and depression. Further review showed the resident had a BIMS score of 6/15 (severe cognitive impairment); required the extensive assistance of one staff member for bed mobility, transfers, dressing, and toilet use; required the limited assistance of one staff member for locomotion on the unit using a wheelchair or walker; and used a bed and chair alarm daily. The following concerns were identified:

a. Observation on 3/25/19 at 3:01 PM showed an alarm was attached to the resident's wheelchair.

b. Interview with CNA #1 on 3/26/19 at 2:08 PM revealed the resident used a chair and bed alarm daily.

c. Review of a nursing note dated 11/28/18 showed "NDO (new doctor order) for bed & chair alarms d/t (due to) res (resident) crawling out of bed on [resident] own and falling out of bed."

d. Review of the falls care plan, last reviewed 11/26/18, did not show the use of a bed or chair

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F 657	Continued From page 21 alarm. e. Interview with the DON on 3/26/19 at 9:34 AM confirmed the care plan did not include the use of the chair or bed alarm. 6. Interview with the DON on 3/26/19 at 10 AM revealed some interventions were written in the care plans, but they had not been updated with the last MDS assessments.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up	F 661		5/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 661	Continued From page 22 care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 1 residents (#29) reviewed for discharge to the community. The findings were: Review of the medical record for resident #29 showed s/he was admitted to the facility on 2/14/19 for respite care. The resident was discharged to the community on 3/11/19. Further review showed no evidence a discharge summary which included a recapitulation of the resident's stay had been completed. Interview with the DON on 3/27/19 at 11:46 AM verified the discharge summary had not been completed.	F 661	This requirement is met as evidenced by: A.) All residents being discharged out of facility will have a discharge summary including recapitulation that will be printed and distributed to the resident at time of discharge. #29 B.) Review all discharges from the past 3 months for accuracy. C.) Nurses will be educated on the proper use and timeliness of discharge summaries by the DON. RN will be trained on how to complete a recapitulation also by the DON. D.) Discharge summary tool that is included in EMR will be utilized as discharge summary. Recapitulation will be completed by RN and included in the discharge summary that will be given to the resident at the time of discharge. E.) DON will create a monitoring tool to keep track of all discharges and to make sure all recapitulations are completed. F.) Monitoring tool will be utilized by the DON monthly to track discharges and to confirm that summaries and recapitulations are completed. This will be reported at the QAPI meeting by DON for a year.	

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	535019	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 684	Continued From page 23	F 684		
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: Based on staff interview, medical record review, and policy and procedure review, the facility failed to perform neurological assessments and post-fall reviews for 1 of 2 (#26) sample residents with falls. The findings were: 1. Review of the 2/4/19 MDS assessment showed resident #26 was admitted to the facility on 10/31/18 and had diagnoses which included anemia and depression. Further review showed the resident had a BIMS score of 6/15 (severe cognitive impairment); required the extensive assistance of one staff member for bed mobility, transfers, dressing, and toilet use; required the limited assistance of one staff member for locomotion on the unit using a wheelchair or walker; and used a bed and chair alarm daily. The following concerns were identified: a. Review of a Post Fall Assessment and Intervention form dated 11/22/18 showed the resident had an unwitnessed fall on 11/21/18 when the resident was found lying on his/her left side under the his/her walker. Neurological checks were initiated; however, the neurological section of the form was left blank.	F 684	This requirement will be met as evidenced by: A.) All residents that have a fall will receive a post fall assessment and neurological checks as outlined in policy and procedure guidelines. Post Fall Assessment tool will be utilized after each resident fall occurrence. Neurological assessment tool will be utilized for 72 hours post fall when resident has an unwitnessed fall or is able to clearly state that they hit their head. We cannot go back and complete a neurological assessment on resident #26, we ensure completion of this assessment on all new incidences. B.) RN/LPN will ensure completion of neurological assessments on all new incidents. C.) Post fall assessment and neurological monitoring tool on EMR with education provided to nursing staff by 5/11/2019 by	5/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 684	Continued From page 24 b. Review of a nurse's note dated 11/22/18 and timed 10:44 AM showed "Neuro checks intact." Further review of the progress notes showed no further neurological assessments had been completed. 2. Review of the policy and procedure "Care Following a Fall" last revised 10/3/14 failed to address the procedure following an unwitnessed fall or a fall with a head injury. 3. Interview with the DON on 3/26/19 at 4:52 PM revealed it was her expectation that any unwitnessed fall or head injury be followed per standard of practice and verified only one neurological assessment had been completed after the resident's fall. In addition she confirmed the policy and procedure did not include the standard of practice and was in the process of being revised.	F 684	the DON. Use of tool can be tracked in the EMR. D.) Monitoring tool will be utilized by the DON monthly to track neurological assessment completion. This will be reported at the QAPI meeting by DON for a year.	
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced	F 727		5/11/19

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F 727	Continued From page 25 by: Based on observation, review of staffing schedules, staff interview, review of the CNO/DON job description, and review of the facility assessment staffing matrix, the facility failed to ensure the services of a registered nurse were utilized for 8 hours a day 7 days a week. In addition the facility failed to ensure the director of nursing served the facility on a full time basis. The census was 29. The findings were: 1. Multiple observations from 3/25/19 to 3/27/19 showed the DON was not readily available in the facility. 2. Interview with the DON on 3/26/19 at 5:08 PM revealed she oversaw both the nursing home and the hospital. She stated the facility had hired a registered nurse as the manager of the facility who will report to her, however that person had not yet started work at the facility. She further stated she was available during the day shift to help with issues. 3. Review of the CNO/DON position description, issued 4/2/15, showed "...the Chief Nursing Officer (CNO) assumes full time administrative authority, responsibility and accountability of the delivery of nursing services for south Big Horn County Hospital and Bonnie Bluejacket Nursing Home...". 4. Review of the March nurse staffing schedule revealed 9 days where an RN was not scheduled (3/1, 3/13, 3/15, 3/18, 3/19, 3/20, 3/22, 3/23, 3/24). Interview on 3/26/19 at 10:50 AM with the DON revealed on weekends the facility was staffed with LPNs. She stated when an RN was not scheduled, there were 2 charge RNs on the	F 727	This requirement will be met as evidenced by: A.) Facility will procure services of a Registered Nurse to ensure they are on staff 8 hours a day 7 days a week. Current Nurse Manager position will be re-categorized to reflect DON status by May 11, 2019. DON position will be full time/40 hours per week. B.) Nurse manager position will be relabeled as Director of Nursing and the job description will reflect the appropriate duties of the DON. Staff scheduler will be educated on regulation requiring RN coverage 8 hours a day 7 days a week. C.) Human Resources will be responsible for ensuring that the DON position is filled and meeting all state regulations. DON will create a monitoring tool for reviewing the nursing schedule to ensure scheduling requirements by CMS are being met. RN coverage will be in place by May 11, 2019. D.) DON will monitor the RN schedule monthly and will report at the QAPI meeting quarterly for the duration of a year. DON position will be filled by May 11, 2019.	

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	535019	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 727	Continued From page 26 hospital side who were immediately available to help as needed. She further added during the week she was always available to help. Review of the facility assessment 2018 showed the staffing matrix was to have one RN or LPN for each shift.	F 727		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (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.	F 756		5/11/19

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F 756	Continued From page 27 §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 and staff interview, the facility failed to ensure the pharmacist recommendations were submitted on a separate written report to the attending physician and the physician's response maintained in the medical record for 1 of 5 sample residents (#11) reviewed for unnecessary medications. In addition the facility failed to develop policies and procedures related to the monthly drug regimen review. The findings were: Review of the pharmacist's medication regimen reviews for resident #11 showed the monthly reviews were being completed, however there was no evidence a separate written report listing irregularities or recommendations was submitted to the physician. Interview with the pharmacist on 3/27/19 at 8:31 AM revealed he had developed a system on his personal computer for completing the monthly reviews and would then transfer the information into the resident's medical record. However, he did not generate a separate report with any irregularities or recommendations to the required facility personnel. Interview with the DON on 3/27/19 at 9:14 AM verified the required information was not in the medical record. In an additional interview on	F 756	This Requirement will be met as evidenced by: A.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Deficiencies in communication, documentation and following through on monthly pharmacy drug regimen review (DRR) as evidenced by Resident #11 will be corrected by compliance with Pharmacy Procedure 7000-15; LTCF Monthly DRR: 1. All facility resident□s medication regimen and medical record will be reviewed by a Consultant Pharmacist monthly. 2. Any irregularities in the medication regimen that are noted by the consultant pharmacist will be communicated in writing to the attending physician, the medical director and the director of nursing. a. The attending physician will receive individual reports specific to particular residents. b. The medical director and director of	

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F 756	Continued From page 28 3/27/19 at 2:44 PM the DON stated a policy and procedure for the monthly medication review had not been developed.	F 756	nursing will receive compilation reports for all residents of the facility. 3. These reports of irregularities, with or without recommendations, will be acted upon within four calendar days. If the attending physician opts to not follow recommendations or act on a reported deficiency, he or she will document their reasoning in the medical record of the patient. 4. Irregularities or medication issues of urgency will be dealt with as soon as possible after the time that they are found through clinical intervention paperwork or direct face-to-face or telephone communication. These results will be reduced to written documentation in the medical record. 5. Trends for irregularities noted on review of medication regimens or in compliance with this procedure will be reported to the appropriate oversight committee and/or cause the initiation of a Quality Assessment and Performance Improvement study (QAPI). B.) While this correction is written for a deficiency noted in Resident #11, the processes will be applicable to all residents and review of each DRR results will assure other residents do not duplicate this deficiency. C.) The procedure for implementing the acceptable plan of correction the specific deficiency cited; The referenced pharmacy procedure will be expedited though our policy and procedure guidelines and communicated to all affected staff and providers. D.) The monitoring procedure to ensure	

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F 756	Continued From page 29	F 756	that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Monitoring tool will be developed in order to ensure that: Compliance will be monitored and improved through an active QAPI process that will measure the percentage of provider responses. Results will be reported to the LTCF QAPI program and Medical Staff Committee on a continuing basis until it is evident that the correction has been hardwired in Bonnie Blue Jacket Nursing Home standard processes, and at that time it will become an issue for Pharmacy Quality Assurance. E.) The title of the person responsible for implementing the acceptable plan of correction. Monitoring tool will be completed monthly and reported on quarterly at the QAPI meeting to ensure: The Director of Pharmacy/Consultant Pharmacist will be responsible to the creation, installation, monitoring and process improvements necessary to see that this deficiency is corrected and does not recur without prompt remedy. All processes of this plan of correction will be complete by 5/11/19, and will be monitored monthly, reported quarterly and continued for 1 year.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/11/19

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F 880	Continued From page 30	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 31 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy and procedure review, the facility failed to implement infection control processes to prevent transmission of infection in 2 random observations and in 2 of 2 laundry rooms. The findings were: 1. Observation on 3/25/19 at 4:24 PM showed CNA #2 transferred resident #23 to the toilet using the sit-to-stand lift. The CNA donned gloves, removed the resident's briefs; removed her gloves and left the bathroom without performing hand hygiene. The CNA came back,	F 880	This requirement will be met as evidenced by: A) Facility policy for the handling and transport of soiled laundry were not being followed. Equipment and furnishings in the laundry rooms were not established to allow for a dirty to clean work flow. Clean laundry was being processed and stored next to the sinks utilized for hand hygiene. Proper PPE was not being utilized when handling laundry contaminated with bodily fluids.	

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F 880	Continued From page 32 donned gloves, and performed peri-care. The CNA touched the clean briefs and the sit-to-stand lift without changing gloves. The CNA removed her gloves, transferred the resident to the wheelchair, positioned the resident's legs with pillows, and then performed hand hygiene. 2. Observation on 3/26/19 at 12 PM of medication pass for multiple residents showed LPN #1 failed to perform hand hygiene between residents. The LPN also failed to perform hand hygiene after obtaining a blood glucose from a resident. 3. Interview with the DON on 3/27/19 at 2:30 PM revealed the expectation was for staff to perform hand hygiene prior to putting gloves on, after removing gloves, and after resident contact. 4. Observation on 3/27/19 at 12:20 PM of laundry room #1 showed a washer and dryer next to a double sink and a rack of clean clothes which hung over part of the sink. The following concerns were identified: a. Interview on 3/27/19 at 12:20 PM with the housekeeping manager revealed the resident's clothes were brought to the laundry room in a bag and soiled clothes were rinsed in the sink prior to going into the washing machine. She further stated the only personal protective equipment staff wore was gloves; she denied wearing a gown or eye protection. b. Observation on 3/27/19 at 12:20 PM of both laundry rooms failed to show a supply of gowns and eye protection. Interview at this time with the housekeeping manager revealed both laundry rooms were used to sort dirty clothes, wash the clothes and hang the clean clothes. c. Observation on 3/27/19 at 12:20 PM showed the soap dispenser to wash hands was	F 880	B) The following have been undertaken to correct these deficiencies: a.The Director of Nursing will in-service nursing staff on the facility policy for handling and transporting soiled laundry and linen including emphasis on utilizing appropriate PPE during these tasks. The in-service will include reminders that items soiled with bodily fluids are to be rinsed in the soiled utility room prior to being bagged and delivered to the laundry room for processing. The Housekeeping Manager will in-service housekeeping staff on facility policy for handling and transporting laundry and linen including emphasis on utilizing appropriate PPE. The Director of Nursing and the Housekeeping Manager will ensure PPE is available for use when handling soiled laundry and linen. b.The equipment and furnishings for processing and storing clean laundry have been removed from the laundry room and placed in the clean linen room. This will allow for access to the sink, soap and hand towels for hand hygiene as well as maintain a proper dirty to clean work flow. c.Per facility policy staff will utilize appropriate PPE when handling laundry contaminated with bodily fluids. C) Nursing in-service will be completed 5/11/2019. Housekeeping in-service was completed 4/15/2019. Relocation of clean laundry processing and storage was	

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F 880	Continued From page 33 hidden by the side of a cabinet behind the clean rack of clothes and the paper towel dispenser was behind the clean rack of clothes. Interview with the housekeeping manager stated staff had to move the clothes to obtain soap for hand hygiene. d. Interview with the Infection Preventionist on 3/27/19 at 2:10 PM revealed gowns, gloves, and eye protection should be readily available, and she was not aware staff wore only gloves to sort the laundry. 5. Review of the Facility Infection Control Policy, revised 4/5/17, showed "...wash hands before and after contact with each patient. Wash hands before gloves are donned and after gloves are removed. Eye and mucus membrane protective devices must be worn if splashing is likely. Moisture resistant cover gowns or aprons must be worn when splashing or clothing contamination is likely..."	F 880	completed 4/8/2019. D) Compliance will be monitored by the Director of Nursing and the Housekeeping Manager. Completion of in-services will be documented by meeting agenda and staff sign-off acknowledging training. Monitoring tool will be created by the DON for hand hygiene monthly tracking. Copies of facility policies on handling and transporting will be made available. This will be monitored monthly and reported on quarterly at QAPI meeting, for the duration of a year.	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property	F 943		5/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 943	Continued From page 34 §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on employee record review, staff interview, and policy review, the facility failed to provide evidence of abuse training in 4 of 4 new employee records (#1, #2, #3, #4). The findings were: 1. Review of employee records showed the following: employee #1 (CNA) was hired on 12/17/18, employee #2 (CNA) was hired on 2/18/19, employee #3 (CNA) was hired on 1/14/19, and employee #4 (dietary aide) was hired on 12/14/18. Further review of the employee records failed to show evidence abuse training was provided. 2. Interview on 3/27/19 at 10:18 AM with director of human resources revealed new staff were to read policies and procedures on abuse, but there was no process in place to verify employee acknowledgment of training. She stated all employees receive abuse training in September. 3. Interview on 3/27/19 at 10:18 AM with the DON confirmed all employees receive abuse training in September, but the facility did not have a process for newly hired employees. 4. Review of the Patient Abuse/Unknown Cause Injury Investigating/Reporting policy, last revised 5/9/16 showed "...Every new employee, upon hire, will receive a copy facility Abuse Policy. ...Prior to providing direct patient care, each new hire will have inservice regarding resident abuse...".	F 943	This requirement will be met as evidence by: A) All new hires starting with the facility will be assigned a vulnerable adult abuse training during their orientation process. All new hires starting with the facility will be provided a copy of the facilities policies and procedures regarding abuse, reporting and investigation during their orientation process and will sign an acknowledgment form indicating receipt of the policy and adherence to the policies and procedures. Employee□s currently out of compliance with completing adult abuse training and acknowledgment of policies will be assigned training by 4/19/2019 and will be required to complete the training by 5/11/2019. Employee□s currently out of compliance with acknowledging policies on abuse, reporting and investigation will be provided the policies and sign the acknowledgment form by 5/11/2019. B) Human resources staff will be educated on staff training requirements involving initial and annual staff awareness training on vulnerable adult abuse training. C) A monitoring tool will be developed in order to ensure every new hire will complete abuse training and has received the facilities policies and procedures on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 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 943	Continued From page 35	F 943	abuse, reporting and investigation. The monitoring tool and training will be implemented by 5/11/2019. D) Human Resource Director will be responsible for implementing the plan of correction and the monitoring tool monthly and report quarterly at QUAPI meetings, to ensure all new hires obtain abuse training and notification of the facilities policies and procedure on abuse, reporting and investigation.	