STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 5/6/19 through 5/9/19. Also reviewed in the course of the survey was complaint intake WY00002663. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on employee file review, staff interview, and facility policy review, the facility failed to ensure the CNA abuse registry was checked prior	F 607	The Human Resources Coordinator was Educated on F607 and Crook County Medical Services' Policy on Abuse	6/7/19

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

Electronically Signed | 05/31/2019

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F 607	Continued From page 1 to hire for 2 of 2 sample CNAs (#1, #2). The findings were: Review of electronic employee files with the HR Manager on 5/9/19 at 9:51 AM showed CNA #1 had a date of hire of 3/6/19, and CNA #2 had a date of hire of 3/20/19. Each had a current CNA license. The following concerns were identified: a. The review showed the facility failed to check the state CNA abuse registry regarding any abuse findings for the 2 CNAs. b. Interview with the HR Manager at that time revealed she was unaware of the requirement to check the CNA abuse registry. c. Review of the undated policy titled, "Abuse, Neglect, and Exploitation" confirmed "The Facility Must: ... 3. Not employ or otherwise engage individuals who: ... b. Have had a finding entered [on] the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property."	F 607	Screening by the DON. A new process was implemented to utilize a checklist upon hire, to ensure that all new hire CNAs have Abuse Screening completed prior to their first shift. An audit will be performed, using an audit tool, by the HR supervisor, on all new hire CNAs to ensure Abuse screening has been performed. Any variances will be corrected immediately and a root cause analysis will be conducted by the QAPI committee at the next monthly meeting to ensure the process is compliant with F607. Results of the audit will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		6/7/19

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F 645	Continued From page 2	F 645		

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing

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F 645	Continued From page 3 facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) determination was completed prior to admission for 1 of 2 sample residents (#77) reviewed. The findings were: Review of the PASRR level 1 showed resident #77 was admitted to the facility on 6/22/18 from home. The date of the review was 6/22/18 and the summary showed the resident was referred to level II for evaluation of mental illness. Review of the PASRR level II showed the initial fax request by the facility was made on 7/12/18 and the level II determination was completed on 7/13/18. The determination showed the nursing home level of care was appropriate with no specialized services recommended. Interview with the social services designee (SSD) on 5/9/19 at 8:30 AM revealed the evaluation was completed after admission due to the resident's need for placement, and difficulty with provider availability to complete the evaluation.	F 645	Resident #17 has a PASRR II in place. All persons involved in the admission process were educated on F645 (PSARR requirement) by DON. The Admission Process was improved by adding an admission checklist that includes PSARR level I and II's be completed prior to admission. An audit will be performed, using an audit tool, by the LTC Manager or designee, on all admissions within 24 hours of admission to ensure the PSARR has been completed. Any variances will be corrected immediately and a root cause analysis will be conducted by the QAPI committee at the next monthly meeting to ensure the process is compliant with F645. Results of the audit will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met.	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		6/21/19

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F 656	Continued From page 5 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop an individualized care plan that addressed all required areas for 2 of 12 sample residents (#7, #26). The findings were: 1. Review of the 3/28/19 quarterly MDS assessment showed resident #7 had diagnoses including Parkinson's disease, anxiety, and depression. The resident displayed "other behavioral symptoms not directed at others" 1-3 days and "rejection of care" 1-3 days. Review of the 4/17/19 at 12:44 AM behavior note showed the resident was "very agitated with everyone staff and other elders [s/he] was yelling and swatting a news paper at any one walking by [his/her] chair. [The resident] was yelling "You need your brain broke." "You need your back broke" "You need your face broke" [s/he] repeated the same thing over and over in a very loud voice upsetting other elders." The following concerns were identified: a. Observation on 5/6/19 at 4:19 PM showed the resident was sitting at a table with coffee and the news paper in front of him/her, the resident repeatedly asked, "Help, will you help me?" The resident appeared confused and non-content, calling out "Please take me away" and "Help me." The staff attempted to re-direct the resident with minimal results. b. Review of the care plan with a 7/9/18 revised date showed no plan related to behaviors. c. Interview with the with the DON on 5/9/19 at 8:15 AM verified the resident had behaviors	F 656	The Care plans on resident #7 and #26 were updated to include the conditions experienced by those residents. The IDT and Nurses were educated by the DON on F656 to ensure understanding of requirements. A checklist is being developed to include conditions that require Care Plan changes or considerations with the purpose of ensuring all Care plans are comprehensive and in compliance with F656. The checklist will be applied to all residents upon their next Care Plan review. An weekly audit will be performed, using an audit tool, by the DON or designee, on all residents after their care plan meeting to ensure checklist items (and other pertinent items) are included in the care plan for 3 months to ensure that all residents are included in this audit. Any variances will be corrected immediately and a root cause analysis will be conducted by the QAPI committee at the next monthly meeting to ensure the process is compliant with F656. Results of the audit will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met.	

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F 656	Continued From page 6 due to Parkinson's-related dementia and a care plan had not been developed. 2. Review of the 11/13/18 admission MDS assessment showed resident #26 was admitted to the facility on 10/31/18 with diagnoses which included malignant neoplasm of the colon. The review showed the resident did not have any pressure ulcers at that time. Review of the 2/13/19 quarterly MDS assessment showed the resident had a stage II pressure ulcer to the coccyx. Observation on 5/8/19 at 10:45 AM with the wound care nurse showed the resident had a pinkish area at the coccyx with two small reddened breakdowns through the skin within the larger healed pinkish area. Staff applied barrier cream at that time. Interview with the wound care nurse at that time showed the resident had weakened tissue at the coccyx area related to radiation treatments. The following concerns were identified: a. Review of the care plan showed the facility failed to address the resident's coccyx wounds in the plan. b. Interview with the DON on 5/8/19 at 4:58 PM confirmed the resident's wound care and preventative measures should be addressed on the care plan.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		6/21/19

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F 684	Continued From page 7 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a change of condition was assessed by the physician for 1 of 2 sample residents (#3) identified with a change in condition. The findings were: 1. Review of the 2/28/19 admission MDS assessment showed resident #3 was cognitively intact with a BIMS score of 13/15. Review of the nurse's note on 5/3/19 at 8:36 AM showed "Data: C/O pain to the back of Left Calf. Action: [Physician] here in LTC and this author explained that resident has Varicose Veins in that area but [s/he] stated that it hurts like to the bone and feels like it is going to break. Response: [Physician] stated that he would be up Saturday and he will take a look at it." The following concerns were identified: a. Review of the medical record failed to show any further mention of the resident's complaints of pain in the leg or any notes related to the physician visit. b. Interview with LPN #1 on 5/8/19 at 2:59 PM revealed she was unsure if the resident had been seen by the physician, and she was unaware of the condition of the resident's leg pain. c. Review of the May 2019 MAR showed 2 PRN orders for pain medications were available with start dates of 2/15/19. One for Tylenol 1 tablet 325 mg every 4 hours, and Tramadol 50 mg every 6 hours. There was no pain medication administered on 5/3/19 other than the scheduled twice daily 600 mg of ibuprofen. d. Interview with the house supervisor and the DON on 5/9/19 at 8:27 AM verified there was	F 684	Resident #3 was assessed by the Physician on 05/09/2019 and found to have no pain or complaints in her left calf. All nursing staff were educated on Alert charting, the log, follow up and interventions related to patient complaints or changes in conditions. The Alert Charting Log was created and will be utilized by nursing staff for resident complaints and concerns in change of condition to ensure follow up is completed. A weekly audit will be performed, using an audit tool, by the DON or designee, on the Alert charting log vs shift change report and Nurses notes to ensure interventions and follow up was completed and documented accurately for 6 weeks. Any variances will be corrected immediately and a root cause analysis will be conducted by the IDT at the next weekly meeting to ensure the process is compliant with F684. Results of the audit and root cause analysis will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met.	

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F 684	Continued From page 8 no follow-up by nursing or the physician in the medical record related to the resident's complaints of pain in the calf. The house supervisor stated there should have been an alert charting done to ensure follow-up. e. Review of the nurse's note completed on 5/9/19 at 8 AM (6 days after the complaint of pain) showed the resident reported no pain at that time. The note showed the physician was asked and he reported it had "slipped his mind" he was supposed to come in on Saturday. The "varicosity is still present but only is "tender" when touched. [Physician] in to see [him/her] this AM..." f. Review of the 5/9/19 at 8:46 AM physician progress note showed the resident was seen and "pulses were appropriate...intermittent leg pain due to varicose veins...continue current treatment."	F 684		
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, medical record review, and staff interview, the facility failed to ensure the environment was free of safety hazards for 1 of 12 sample residents (#24). The findings were: Review of the 2/17/19 quarterly MDS assessment for resident #24 showed s/he was admitted to the	F 689	Resident #24's concentrator was moved to ensure that the O2 tubing isn't a tripping hazard on 05/09/2019. All nursing staff were educated about tripping hazards of O2 tubing and interventions to fix the problem. Weekly rounds/audit will be performed,	6/14/19

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F 689	Continued From page 9 facility on 7/20/18 with diagnoses which included heart failure, hypertension, and chronic obstructive pulmonary disease. The review showed the resident required supplemental oxygen, required supervision for transfer, and was independent for walking in the room with set up help only. The following concerns were identified: a. Observations on 5/6/19 at 4:46 PM and 5/8/19 at 10:14 AM showed the resident was in a recliner in his/her room. The resident was connected by oxygen tubing to an oxygen concentrator located across the room. The tubing was coiled across the walkway. b. Observation on 5/8/19 at 10:23 AM with LPN #1 showed the resident's oxygen tubing was still coiled across his/her walkway in her room. Interview with the LPN #1 at that time confirmed the resident's oxygen tubing was presenting a trip hazard, and she would "brainstorm" with staff to eliminate the potential trip hazard the oxygen tubing posed. c. Interview with the DON on 5/8/19 at 4:58 PM confirmed the resident had oxygen tubing over his/her floor and bundled in an unsafe manner. She stated a team was discussing ways to make the use of the oxygen tubing safer.	F 689	using an audit tool, by the LTC Manager or designee, to ensure that there are no Oxygen tubing that is a tripping hazard for 6 weeks. Any variances will be corrected immediately and a root cause analysis will be conducted by the IDT committee at the next weekly meeting to ensure the process is compliant with F689. Results of the audit will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		6/21/19

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F 812	Continued From page 10 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 and staff interview, the facility failed to ensure equipment in the kitchen was maintained in a sanitary condition. The findings were: 1. Observation on 5/6/19 at 3:35 PM showed 2 plastic food containers stored on a clean shelf were noted to be in poor condition. The containers were damaged with cracks and fissures in the plastic. Also the hood vents above the range were heavily soiled with grease and dust. 2. Interview with the Certified Dietary Manager on 5/8/19 at 11:25 AM verified the 2 containers were in poor condition and were discarded; he also stated the cleaning of the hood vents required the help of maintenance and the last time the vents were removed for cleaning was in December. 3. According to Food code 2017, Public Health Service: 4-601.11 "...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 812	The Kitchen Manager and Maintenance Manager were educated on F812 by the Director of Operations. The hood Vent cleanings have been increased from twice a year to 4 times a year to ensure compliance with F812. A log of the Hood Vent Cleanings will be kept and reviewed/audited quarterly for 9 months,by the Maintenance Director, to ensure that the cleanings are being completed. Any delays in the cleaning schedule will be completed immediately and a root cause analysis will be conducted by the QAPI committee at the next monthly meeting to ensure the process is compliant with F812. Results of the audit will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met. An weekly audit will be performed, using an audit tool, by the Director of Operations or designee, to ensure that all Food storage containers are in good condition	

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F 812	Continued From page 11 4. According to Food Code 2017, U.S. Public Health Service 4-101.11: "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be ...(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition."	F 812	for 4 weeks, then quarterly x 3 quarters. Any variances will be corrected immediately and a root cause analysis will be conducted by the QAPI committee at the next monthly meeting to ensure the process is compliant with F812. Results of the audit will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of the infection control program information and staff interview, the facility failed to ensure an antibiotic stewardship program was in place that included protocols and a defined system. The census was 26. The findings were: Review of the facility infection control program documentation showed no concerns with prescribed use of antibiotics. However, there was no defined stewardship of the use of antibiotics in the facility, or a policy to address antibiotic stewardship. Interview with the infection control preventionist on 5/9/19 at 9:41 AM confirmed the facility did not currently have an antibiotic	F 881	A Policy was developed to address Antibiotic Stewardship. It will be presented at the next Medical Staff Meeting to ensure buy in from the Providers. ABX Tracker Program was purchased. This program meets the tracking/trending and infection criteria and communication tools/documentation requirements defined under the Antibiotic Stewardship Program. It is confirmed to start on 07/01/2019. Until that time, all infections are confirmed using McGreers Criteria for necessity of antibiotic therapy and all infections are	6/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 12 stewardship program, and the facility was in the process of formulating a policy.	F 881	logged, tracked, trended to ensure compliance with F881. A weekly audit will be performed, using an audit tool, by the DON or designee, on all residents who present with signs or symptoms of infection and receive antibiotics to ensure compliance with F881 for 6 weeks. Any variances will be corrected immediately, the staff will receive education on the necessity of Antibiotic Stewardship, and a root cause analysis will be conducted by the IDT at the next weekly meeting to ensure the process is compliant with F881. Results of the audit will be reported/monitored at the monthly QAPI meeting until such time that consistent substantial compliance has been met.	