STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	06/13/2019

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 6/10/19 through 6/13/19. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living ADON- Assistant Director of Nursing 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 637 SS=E	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to complete a	F 637		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-25-19

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

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F 637	Continued From page 1 significant change MDS assessment for 4 of 5 sample residents (#8, #45, #55, #56) who had a significant change. The findings were: 1. Review of the 1/26/19 annual MDS assessment showed resident #8 required supervision for eating, limited assistance for dressing, and weighed 193 pounds with no significant weight loss. Review of the 4/6/19 quarterly MDS assessment showed the resident had declined and was totally dependent for dressing, and eating now required extensive assistance. The assessment further showed the resident's weight was 186 pounds and was coded as significant weight loss of more than 5% and was not on a physician prescribed weight loss program. The following concerns were identified: a. Observation on 6/12/19 at 12:05 PM showed the resident was seated at the dining table and although there was food in front of him/her, there was no attempt made to eat. At 12:15 PM CNA #1 sat and assisted the resident by placing the sandwich into his/her hands and bringing the food to the resident's mouth. b. Review of the medical record failed to show a significant change MDS assessment was completed. 2. Review of the 12/29/18 quarterly MDS assessment showed resident #56 was independent for bed mobility, walking in room and in corridor, and locomotion on the unit. Review of the 3/16/19 quarterly MDS assessment and the 5/18/19 annual MDS assessment showed the resident had declined in these areas and now required extensive assistance for bed mobility and transfers. Walking and locomotion had also declined to extensive assistance by the 5/18/19 annual MDS assessment. Review of the medical	F 637	F 637 1. Residents #8, 45, 55 and 56 were identified as being affected. All 4 residents have had more recent MDS assessments completed that reflect their current status accurately and care is being provided accordingly. 2. No other residents were identified as being affected. All residents experiencing a significant change have the potential to be affected. All residents are being reviewed to verify no other significant change assessments were missed. 3. Inservices were conducted with the MDS care plan team to re-educate them on when a significant change assessment is to be completed. 4. DON and/or designee will review any residents noted to have a significant change in weight, condition or ADL status to verify a significant change MDS is completed if required. This review will include 3-4 residents weekly that are due for a quarterly assessment to verify if a change has occurred that would require a significant change assessment. 5. DON and/or designee will report results of reviews to QAPI committee monthly for the next 60 days to monitor compliance. The QAPI committee will evaluate results to determine if current plan of correction is effective or if additional audits and/or education is needed and will revise plan as necessary to ensure compliance.	7/1/19

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F 637	Continued From page 2 record showed a significant MDS assessment was not completed. 3. Review of the 1/5/19 quarterly MDS assessment showed resident #45 was independent for all ADLs with the exception of toilet use and personal hygiene which required supervision, and bathing which required extensive assistance. Review of the 3/16/19 quarterly MDS assessment showed a decline in ADLs including extensive assistance for transfers and toilet use, and total dependence for bed mobility, locomotion, dressing, personal hygiene, and bathing. The following concerns were identified: a. Observation on 6/11/19 at 1:59 PM showed the resident transferred from the wheelchair to a recliner with the use of a gait belt and 2 CNAs. b. Review of the medical record showed a significant MDS assessment was not completed. 4. Review of the 12/19/18 admission MDS assessment showed resident #55 required limited assistance for transfers and toilet use. Review of the subsequent quarterly MDS assessment dated 3/23/19 revealed the resident declined to extensive assistance for transfers and toilet use, however a significant change MDS was not completed. 5. During an interview on 6/12/19 at 3:53 PM the MDS coordinator stated she did not complete significant change MDS assessments for residents #8, #45, #55, or #56 because she felt it was a result of better CNA documentation. However, she stated she was unable to provide evidence to show it was a documentation issue and not a true significant change.	F 637		
F 657	Care Plan Timing and Revision	F 657		

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F 657 SS=D	Continued From page 3 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-- (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 medical record review and staff and resident interview, the facility failed to ensure the care plan was updated to reflect current needs for 1 of 20 sample residents (#50). The findings were: 1. During an interview on 6/11/19 at 10:04 AM resident #50 stated s/he currently had a urinary	F 657	F657 1. Resident #50 was identified as being affected. The care plan for Resident #50 was updated to document the UTI. 2. No other residents were identified as being affected. All residents have the potential to be affected. All other care plans are being reviewed to verify accuracy. 3. Staff are being re-educated on updating care plans and using acute care plans when a short term change is noted such as a UTI. 4. DON and/or designee will audit 3-4 care plans weekly for the the next 60 days to verify the care plans are accurately reflecting the residents' needs. 5. Don and/or designee will report results of audits to QAPI committee monthly for the next 60 days to monitor for ongoing compliance. The QAPI committee will evaluate results to determine if current POC is effective or if additional audits and/or education is needed and will revise plan as necessary to ensure compliance.	7/1/19

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F 657	Continued From page 4 tract infection (UTI). Review of nursing notes showed on 5/31/19 urine was obtained for a UA (urinalysis). Review of the UA results received by the facility on 6/1/19 showed ">100,000 cfu/ml Escherichia coli." Review of physician orders showed on 6/3/19 the physician ordered Detrol LA (bladder relaxant) 4 mg daily while waiting for the UA and culture. Review of the current care plan (last updated 5/31/19) showed the UTI was not addressed. During an interview on 6/13/19 at 10:25 AM the MDS coordinator confirmed the UTI was not addressed. She stated she had not been putting UTIs on care plans for residents.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide services to maintain personal hygiene for 1 of 20 sample residents (#70). The findings were: Review of the 5/24/19 quarterly MDS assessment showed resident #70 had a brief interview for mental status (BIMS) score of 11 of 15 (moderate cognitive impairment), and was independent for ADLs but required some physical help in part of the bathing activity. His/her diagnoses included diabetes, depression, bipolar, low back pain, arthritis, and dementia without behavioral disturbance. Review of the resident's care plan showed bathing was to be done twice a week. The following concerns were identified:	F 677	1. Resident #70 was identified as being affected. Resident #70's care plan was revised to document the correct shower schedule of at least one time weekly. 2. No other residents were identified as being affected. All residents have the potential to be affected. All shower schedules were reviewed to verify that showers were being given at least weekly. 3. Staff are being re-educated on ensuring all residents receive at least one shower /bath weekly and, if residents refuse showers, the refusal is to be documented. 4. DON and/or designee will audit shower/bath sheets weekly for the next 60 days to verify that residents are receiving at least one time per week or, if they refuse to receive a shower, staff are documenting so. 5. DON and/or designee will report results of audits to QAPI committee monthly for the next 60 days to monitor for compliance. QAPI committee will evaluate results to determine if current POC is effective or if additional audits and/or education is needed and will revise plan as necessary to ensure compliance.	7/1/19

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F 677	Continued From page 5 a. Observation on 6/11/19 at 10:08 AM showed the resident appeared unkempt, with uncombed, greasy hair. Observation on 6/12/19 at 9:30 AM showed the resident was in the hallway sitting in a wheelchair, his/her hair was uncombed, and appeared greasy. b. Review of the June 2019 bathing documentation showed the resident was to be bathed during the day shift on Thursdays and Saturdays. The documentation showed bathing did not occur for 4 days from June 1st through June 4th, and showed 5 days without a bath from June 6th through June 11th. c. Review of the bathing information for May 2019 showed the resident was bathed once a week on 5/5/19, 5/10/19, 5/19/19 and 5/26/19. d. Interview with the ADON on 6/12/19 at 2:24 PM confirmed the baths were not being provided as care planned and had not been documented as refused. In addition, he confirmed the bathing documentation was confusing as to what month they were actually reflecting.	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		

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F 755	Continued From page 6 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policy and procedure, the facility failed to ensure medications available for use were not expired in 2 of 4 medication storage areas (blue medication cart, north storage room). The findings were: 1. Observation during medication pass on 6/11/19 at 4:07 PM showed a Novolog 100 unit/milliliter multiple dose vial in the blue medication cart with an expiration date of 6/7/19. LPN #1 drew up 4 units from this vial into the syringe and was preparing to administer the medication. Interview at that time confirmed the medication was past the written expiration date and was available for resident use. 2. Observation of the north medication storage room on 6/12/19 at 11:21 AM showed an	F 755	1. No residents were identified as being affected. 2. All residents receiving medications or vaccinations have the potential to be affected. The insulin and influenza vaccine bottles were immediately removed. A review of the resident's blood sugars that were recorded after the expiration date of 6/7 of the insulin was conducted and revealed no abnormal levels. A review of the vaccination log was conducted and confirmed that no influenza vaccines had been administered after the vaccine expired. 3. Licensed nursing staff are being re-educated on removal of expired medications and/or vaccines immediately from medication carts and med rooms. 4. DON and/or designee will audit all med carts and medication rooms weekly for the next 60 days to verify that expired meds have been removed. 5. DON and/or designee will report results of audits to the QAPI committee monthly for the next 60 days to monitor compliance. QAPI committee will evaluate results to determine if current POC is effective or if additional audits and/or education is needed and will revise plan as necessary to ensure compliance.	7/1/19

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F 755	Continued From page 7 influenza vaccine 5 ml multiple use vial with an expiration date of 5/30/19. Interview with LPN #1 at that time confirmed the medication had expired and was available for use. 3. Review of the policy "Storage of Medications" last revised April 2007, showed "...4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."	F 755		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on resident interview, medical record review and staff interview, the facility failed to ensure laboratory results were promptly reported to the physician for 1 of 5 sample residents (#50) reviewed for laboratory services. The findings were: During an interview on 6/11/19 at 10:04 AM resident #50 stated s/he currently had a urinary	F 773	1. Resident #50 was identified as being affected. Resident #50's UA results were obtained, MD notified and antibiotics were started on 6/13/19. 2. All residents who have labs drawn have the potential to be affected. An audit was conducted to verify that no other lab results were missing. 3. All ordered labs will be entered on a lab requisition tracking log and checked daily by licensed nursing staff to monitor for timely lab results and MD notification. Licensed nurses are being educated on this lab tracking process. 4. DON and/or designee will conduct weekly audits of the tracking log for the next 60 days to verify compliance. 5. DON and/or designee will report audit results to QAPI committee monthly for the next 60 days to monitor compliance. QAPI committee will evaluate results to determine if current POC is effective or if additional audits and/or education is needed and will revise plan as necessary to ensure compliance.	7/1/19

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F 773	Continued From page 8 tract infection (UTI). Review of nursing notes showed on 5/31/19 urine was obtained for a urinalysis (UA). Review of UA results received by the facility on 6/1/19 showed ">100,000 cfu/ml Escherichia coli, susceptibility to follow." Review of physician orders showed on 6/3/19 the physician ordered Detrol LA [bladder relaxant] 4 mg daily while waiting for the culture and sensitivity report. Further review of the medical record showed no culture and sensitivity report. During an interview on 6/13/19 at 9 AM the infection control preventionist looked at the medical record and was unable to locate the culture and sensitivity report. She stated the resident had not yet been started on an antibiotic for the UTI. On 6/13/19 at 9:53 AM the infection control preventionist stated she had to get the culture and sensitivity report from the lab, and stated the lab never sent it to them or to the physician.	F 773		
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 medical record review, staff and resident interviews, and review of policies and facility infection documentation, the facility failed to maintain an infection control system to monitor	F 881	1. Resident #50 was identified as being affected. Resident #50's UA results were obtained, MD was notified, antibiotics were started and the UTI was added to the infection control tracking log on 6/13/19. 2. All other residents with an infection were reviewed to verify no other infections or antibiotics were missing from the infection control tracking log. 3. The infection control preventionist and nursing staff are being re-educated on entering infections on the infection control log so infections and antibiotics can be tracked. 4. DON and/or designee will audit the infection control log weekly for the next 60 days to verify all known infections are documented on the log for tracking. 5. DON and/or designee will report results of audit to QAPI committee monthly for the next 60 days to monitor ongoing compliance. QAPI committee will evaluate results to determine if current POC is effective or if additional audits and/or education is needed and will revise plan as necessary to ensure compliance.	7/1/19

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F 881	Continued From page 9 infections and antibiotic use for 1 of 2 sample residents (#50) reviewed for infections. The findings were: During an interview on 6/11/19 at 10:04 AM resident #50 stated s/he currently had a urinary tract infection (UTI). Review of nursing notes showed on 5/31/19 urine was obtained for a urinalysis (UA). Review of UA results received by the facility on 6/1/19 showed ">100,000 cfu/ml Escherichia coli, susceptibility to follow." Review of physician orders showed on 6/3/19 the physician ordered Detrol LA [bladder relaxant] 4 mg daily while waiting for the culture and sensitivity report. The following concerns were identified: a. Further review of the medical record showed no evidence of a culture and sensitivity report. b. During an interview on 6/13/19 at 9 AM the infection control preventionist looked at the medical record and stated she was unable to locate the culture and sensitivity report. She stated the resident had not yet been started on an antibiotic for the UTI. c. Review of infection surveillance documentation with the infection control preventionist on 6/13/19 at 9 AM revealed she did not have the UTI listed for resident #50 and was not aware of the UTI. d. On 6/13/19 at 9:53 AM the infection control preventionist stated she had to get the culture and sensitivity report from the lab, and stated the lab never sent it to them or to the physician. She stated both the nurses and herself failed to follow up on the culture and sensitivity report. e. Review of the facility's policy "Antibiotic Stewardship" (revised December 2016) showed "When a culture and sensitivity (C&S) is ordered	F 881		

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F 881	Continued From page 10 lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued."	F 881		