STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CODY REGIONAL HEALTH LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/15/19 to 7/18/19. Also reviewed in the course of the survey were complaint intakes WY00002801,WY00002835, and WY00002851. The following common abbreviations are used throughout this document. BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set POA: Power of Attorney RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 604		8/21/19

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

Electronically Signed | 08/09/2019

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F 604	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure personal alarms were evaluated as potential restraints for 3 of 3 sample residents (#15, #24, #51). The findings were: 1. Observation on 7/16/19 at 2:23 PM showed resident #15 was seated in a recliner chair with a personal alarm used to alert staff if s/he were to get up. Review of the 4/22/19 quarterly MDS assessment showed the resident used the personal alarm on the chair and the bed daily. Review of the 11/29/18 care plan showed the alarms were used to address the resident's high risk for falls. Review of the medical record showed there was no evaluation to determine if the alarms were considered to be restraints or inhibited the resident's freedom of movement and activity. 2. Observation on 7/16/19 at 2:31 PM showed resident #24 was seated in a recliner chair with a	F 604	1.Residents #15, #24 and # 51 were assessed by the DON/designee to ensure that the alarms do not inhibit their freedom of movement and activity. If the alarm is found to be inhibiting or restricting movement another alarm choice will be attempted and assessment completed. If this choice is also found to be inhibiting another choice will be attempted and assessment completed. If no alarm options are found to be non-inhibitive, use of alarms will not be utilized for this resident. All choices will be noted on the Care Plan and Kardex. 2.All current residents with alarms being utilized will be assessed by the DON/designee to ensure that the alarms do not inhibit their freedom of movement and activity. If the alarm is found to be inhibiting another alarm choice will be attempted and assessment completed. If this choice is also found to be inhibiting another choice will be attempted and	

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F 604	Continued From page 2 personal alarm used to alert staff if s/he were to get up. Review of the 5/4/19 quarterly MDS assessment showed the resident used the personal alarm on the chair and the bed daily. Review of the 3/1/19 care plan showed the alarms were initiated to address the resident's history of falls. Review of the medical record showed there was no evaluation to determine if the alarms were considered to be restraints or inhibited the resident's freedom of movement and activity. 3. Observation on 7/16/19 at 2:20 PM showed resident #51 was seated in a recliner chair with a personal alarm used to alert staff if s/he were to get up. Review of the 3/6/19 annual MDS assessment showed the resident used the personal alarm on the chair and the bed daily. Review of the 3/11/19 care plan showed the alarms were initiated to address the resident's high risk for falls. Review of the medical record showed there was no evaluation to determine if the alarms were considered to be restraints or inhibited the resident's freedom of movement and activity. 4. Interview on 7/17/19 at 4:44 PM with the DON, confirmed evaluations related to the use of the personal alarms were not completed. 5. According to CMS's MDS 3.0 RAI Manual, page p-9: "Individualized, person-centered care planning surrounding the resident's use of an alarm is important to the resident's overall well-being. When the use of an alarm is considered as an intervention in the resident's safety strategy, use must be based on the assessment of the resident and monitored for efficacy on an ongoing basis, including the	F 604	assessment completed. If no alarm options are found to be non-inhibitive, use of alarms will not be utilized for this resident. All choices will be noted on the Care Plan and Kardex. 3.Upon determination of need for a new alarm use, the resident will be assessed by the DON/designee to ensure that the alarms do not inhibit their freedom of movement and activity. If the alarm is found to be inhibiting another alarm choice will be attempted and assessment completed. If this choice is also found to be inhibiting another choice will be attempted and assessment completed. If no alarm options are found to be non-inhibitive, use of alarms will not be utilized for this resident. All choices will be noted on the Care Plan and Kardex. 4.A) The IDT (Interdisciplinary team) will determine new alarm use in morning meetings. B) The assessments will be reviewed by the IDT in morning meetings to determine possible need for alarm choice change. C) The DON/designee will present the alarm use data at the QAPI meetings for review.	

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F 604	Continued From page 3 assessment of unintended consequences of the alarm use and alternative interventions. There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident. When an alarm is used as an intervention in the resident's safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident."	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		8/28/19

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F 609	Continued From page 4 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, State Survey Agency incident database review, resident and staff interview, review of facility grievance log, and policy and procedure review, the facility failed to ensure allegations of abuse were reported for 2 of 2 sample residents (#33, #52) with allegations of abuse or misappropriation of resident property. The findings were: 1. Review of the quarterly MDS assessment dated 5/9/19 showed resident #33 had a BIMS score which was not completed and a staff assessment which showed his/her short-term memory and long-term memory were intact. Interview with the resident on 7/16/19 at 9:27 AM revealed the resident reported a missing wallet with $100 in it to the head of the housekeeping department. The resident revealed the wallet was returned; however, the money remained missing. The following concerns were identified: a. Review of the grievance log showed a grievance was filed on 7/9/19 regarding a "Missing wallet and a $100 from last week when [his/her] son was here." Further review showed the facility emailed a notification to staff and laundry. The log indicated the wallet was subsequently found and the "resident was satisfied." b. Review of a social work progress note dated 7/15/19 and timed 11:16 AM showed "Late Entry: Note Text: The resident reported that s/he was missing his wallet. Nursing reports the wallet was found and that [s/he] is not concerned about the funds according to report. Administrator	F 609	Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Late report has been sent to the WY OHLS reporting system for resident # 33 and resident #52 1.Any alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property as defined in 483.12(c)(1) will be reported through the OHLS website reporting, even if allegations are not substantiated. During the investigation process, if the investigation determines that the allegations are not substantiated based on staff or resident interviews, the investigation will continue in order to comply with our policy of interviewing staff, roommates, residents, and even family, as warranted. 2.The facility utilizes weekly Ambassador rounds and Employee rounding to monitor and interview for any alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of	

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F 609	Continued From page 5 indicates the grievance is closed per IDT [interdisciplinary team]." c. Review of the State Survey Agency incident report database showed no evidence this allegation was reported to the agency. d. Interview with the administrator, social services director (SSD), and DON on 7/18/19 at 10:12 AM revealed they were unsure how the resident's wallet went missing and the wallet was found within 48 hours in the resident's room. The $100 was not in the wallet and an investigation was not initiated. e. Interview with the SSD on 7/18/19 at 11:27 AM confirmed an investigation was not completed and revealed the facility should have completed an investigation. 2. Review of a social services note dated 4/16/19 and timed 3:11 PM for resident #52 revealed the following: "Staff reports [the resident] believes that a male CNA has been rough with [him/her]. This social worker visited with [the resident]. The writer asked [him/her] if [s/he] feels as though our staff has been mean to [him]her], [s/he] said no. This writer asked if our staff has been rough with [him/her], [s/he] said no. This writer asked if male staff has been rough with [him/her], [s/he] said, 'No, you all do a wonderful job.' Administration notified." The following concerns were identified: a. Review of the State Survey Agency incident report database showed no evidence this allegation of abuse was reported to the agency. b. Interview with the social worker on 7/18/19 at 11:50 AM confirmed this allegation was not reported to the State Survey Agency and local law enforcement or APS (adult protective services). 3. Review of the undated policy titled, "Abuse-Identification, Prevention, and Reporting	F 609	resident property as defined in 483.12(c)(1). 3.LTC employees will be provided further education by the DON or designee and in-service regarding the regulatory requirements of F-609 The Administrator, Director of Nursing, and Social worker will collaborate, as schedules allow, regarding reports to the state for alleged violation as defined in 483.12(c)(1) to ensure continued compliance. 4.Audits of Ambassador and Employee rounding are reviewed at each monthly QAPI meeting for any allegations and appropriate reporting and investigations.	

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F 609	Continued From page 6 of Crime Against a Resident" showed "Reporting: Any individual providing services to the facility who witnesses or receives a report of an allegation of mistreatment, neglect, abuse or misappropriation of residents' funds or property is required to report the allegation to a supervisor who must ensure that the allegation is further reported to the State Survey and Certification agency and the Department of Family Services (DFS) Adult Protection agency. Failure to report is grounds for disciplinary action."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, incident log review, grievance log review, staff interview, and policy and procedure review, the facility failed to ensure an allegation of abuse was thoroughly	F 610	1. Late report has been sent to the WY OHLS reporting system for resident # 33 and resident #52. Any alleged violations involving abuse,	8/28/19

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F 610	Continued From page 7 investigated for 1 of 1 sample resident (#52). The findings were: 1. Review of a social services note dated 4/16/19 and timed 3:11 PM for resident #52 revealed the following, "Staff reports [the resident] believes that a male CNA has been rough with [him/her]. This social worker visited with [the resident]. The writer asked [him/her] if [s/he] feels as though our staff has been mean to [him]her], [s/he] said no. This writer asked if our staff has been rough with [him/her], [s/he] said no. This writer asked if male staff has been rough with [him/her], [s/he] said, 'No, you all do a wonderful job.' Administration notified." The following concerns were identified: a. Review of the incident and grievance logs showed the facility failed to list this abuse allegation. b. Review of the entire medical record showed, with the exception of the 4/16/19 social services note, this abuse allegation was not further documented. c. Interview with the social worker on 7/18/19 at 11:50 AM confirmed she interviewed the resident and the resident's spouse, and felt the investigation was closed. She confirmed staff and other residents were not interviewed, and this was a group administrative decision. 2. Review of the undated policy titled, "Abuse-Identification, Prevention, and Reporting of Crime Against a Resident" showed "Investigation: All reports of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of residents' funds or property must be reported immediately to the Administration for a thorough investigation, which will include interviews of residents, roommates,	F 610	neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property as defined in 483.12(c)(1) will be reported through the OHLS website reporting, and investigated according to regulations and facility policy, even if allegations are not substantiated. During the investigation process, if the investigation determines that the allegations are not substantiated based on staff or resident interviews, the investigation will continue in order to comply with our policy of interviewing staff, roommates, residents, and even family, as warranted. 2.The facility utilizes weekly Ambassador rounds and Employee rounding to monitor and interview for any alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property as defined in 483.12(c)(1). Any alleged violation will be immediately investigated according to regulation and facility policy. 3.LTC employees will be provided further education and in-service by the DON or designee regarding the regulatory requirements of F-610. The Administrator, Director of Nursing, and Social worker will collaborate, as schedules allow, regarding reporting and investigating to the state for alleged violation as defined in 483.12(c)(1) to ensure continued compliance. 4.Audits of Ambassador and Employee	

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F 610	Continued From page 8 family members, and any other individuals who may have knowledge of the allegation. Additional residents who have been provided care by any individuals alleged to have committed the abuse will also be interviewed, along with other employees who have worked with those individuals."	F 610	rounding are reviewed at each monthly QAPI meeting for any allegations and appropriate reporting and investigations.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §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;	F 623		8/28/19

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F 623	Continued From page 9	F 623		

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 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

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F 623	Continued From page 10 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a written transfer notice was issued to 3 of 4 sample residents (#13, #37, #52) who transferred to the hospital. The findings were: 1. Review of a progress note dated 5/8/2019 and timed 12 PM for resident #13 showed "Nurse Note Late Entry: Note Text: Admission Nurses Note Arrival time and mode: [Resident's name] arrived at 1000 on 5/7/19 via wheelchair with Oxygen..." The following concerns were	F 623	1.Transfer and Discharge notices have been given/sent to residents #13, #37 and #52 and/or responsible party along with a letter of explanation as to why they are receiving it. A review of transfer & discharges since 7/18/19 was completed and found that there were no transfer & discharges that did not have the required forms completed. 2.Transfer and Discharges will be monitored daily or as needed to insure	

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F 623	Continued From page 11 identified: a. Interview with the administrative assistant on 7/17/19 at 1:47 PM revealed the resident discharged from the facility on 5/5/19 and re-admitted to the facility on 5/8/19. Further interview revealed the facility did not issue a written transfer notice to the resident or resident's representative at the time the resident discharged. 2. Review of the medical record showed resident #37 was discharged to the hospital on 7/14/19. The resident remained in the hospital during the survey and according to the 7/14/19 MDS assessment for tracking was anticipated to return. Interview on 7/17/19 at 3:17 PM with administrative assistant #1 revealed a notice of transfer had not been issued. 3. Review of the 6/6/19 quarterly MDS assessment showed resident #52 had diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms, and the resident utilized a urinary catheter. Review of a nursing progress note dated 4/5/19 and timed 8:33 PM showed the resident was sent to the emergency department on 2/8/19, and was treated and returned within 24 hours. The following concerns were identified: a. Review of the entire medical record showed the facility failed to notify the POA in writing of the 2/8/19 transfer to the ED. b. Interview with the DON on 7/18/19 at 12:22 PM confirmed the facility failed to issue a transfer notice to the POA for the 2/8/19 transfer to the ED.	F 623	that any transfer or discharge has the required notice completed per regulatory requirements. This will be recorded on an audit log. 3.The Staff will be educated by the DON or designee on the proper use of the Notice of Transfer or Discharge form. 4.The audit log of monitoring transfer and discharge notices will be brought to the monthly QAPI meeting for review and to ensure continued 100% compliance. Any non-compliance will be reviewed to identify the cause with corrective measures implemented.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		8/28/19

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F 625	Continued From page 12 §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) 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, staff interview, and policy and procedure review, the facility failed to ensure a written notice of the bed-hold policy was issued to 2 of 4 sample residents (#13, #52) who transferred to the hospital. The findings were: 1. Review of a progress note dated 5/8/2019 and	F 625	1.Bed Hold Notices have been given/sent to residents #13, and #52 and/or responsible party along with a letter of explanation as to why they are receiving it. A review of transfer & discharges since 7/18/19 was completed and found that there were no transfer & discharges that did not have the required bed hold notice	

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F 625	Continued From page 13 timed 12 PM for resident #13 showed "Nurse Note Late Entry: Note Text: Admission Nurses Note Arrival time and mode: [Resident's name] arrived at 1000 on 5/7/19 via wheelchair with Oxygen..." The following concerns were identified: a. Interview with the administrative assistant on 7/17/19 at 1:47 PM revealed the resident discharged from the facility on 5/5/19 and re-admitted to the facility on 5/8/19. Further interview revealed the facility did not issue a written bed hold policy to the resident or resident's representative at the time the resident discharged. 2. Review of the 6/6/19 quarterly MDS assessment showed resident #52 had diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms, and the resident utilized a urinary catheter. Review of a nursing progress note dated 4/5/19 and timed 8:33 PM showed the resident was transferred to the ED on 2/8/19. The following concerns were identified: a. Review of the entire medical record showed the facility failed to notify the POA in writing of the bed hold policy for the 2/8/19 transfer to the ED. b. Interview with the DON on 7/18/19 at 12:22 PM confirmed the facility failed to provide a bed hold policy to the POA for the 2/8/19 transfer to the ED. 3. Review of the policy titled "Bed-Hold and Readmission" provided by the facility on 7/18/19 showed "...Policy-The LTCC will provide written information to residents and the resident's representative before transferring to a hospital or going on therapeutic leave that specifies the duration during which the resident is permitted to	F 625	forms completed. 2.Transfer and Discharges will be monitored daily or as needed to insure that any transfer or discharge has the required bed hold notice completed per regulatory requirements. This will be recorded on an audit log. 3.The Staff will be educated by the DON or designee on the proper use of the Bed Hold Notice. 4.The audit log of monitoring transfer and discharge notices will be brought to the monthly QAPI meeting for review and to ensure continued 100% compliance regarding the Bed Hold Notice requirements. Any non-compliance will be reviewed to identify the cause with corrective measures implemented.	

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F 625	Continued From page 14 return and resume residence. Procedure-the LTCC will issue the first bed hold notice in advance of any transfer (i.e., in the admission packet). The second notice will be provided to the resident and/or resident's representative, if applicable. at the time of transfer. In cases of emergency transfer, the bed-hold notice will provided withing 24 hours..."	F 625		
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 medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure accurate coding on sections of the MDS assessments for 2 of 23 sample residents (#17, #35). The findings were: 1. Review of the 4/24/19 quarterly MDS assessment showed the BIMS was conducted for resident #17. The resident was able to sometimes understand others and sometimes make him/herself understood. The following concerns were identified: a. Review of the BIMS showed the score was 6 out of 15. This had been overridden to be a "99" (unable to complete interview). b. Review of section D showed the resident mood interview was not conducted. This was marked "No (resident is rarely/never understood)." The staff interview for resident mood was conducted instead. c. Interview with the social worker on 7/18/19	F 641	1.As we are unable to go back and correct the BIMs already submitted for residents #17 and #35, the BIMs and PHQ9 for their next scheduled MDS were completed on 7/19/19 for resident # 17, and 8/5/19 for resident #35. Both of these assessments were completed according to the new RAI manual rules. Social worker reviewed the RAI manual for changes that took place in October 2018. Education was provided to social worker. Effective immediately post survey, the social worker is adhering to the new RAI policy effective from October 2018 completing social work assessments i.e. BIMS and PHQ-9 with the resident regardless of cognitive score. 2.An audit was completed for all BIMs assessments from date of survey exit to alleged date of correction of 8/28/19. All assessments were completed according	8/28/19

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F 641	Continued From page 15 at 9:40 AM revealed she overwrote the BIMS score and conducted the staff assessment for mental status in its place. Additionally, she stated based on that decision, the resident interview for mood was not conducted. She understood this to be the correct way to code these areas of the MDS assessment. 2. Review of the 5/11/19 quarterly MDS assessment showed resident #35 was understood, and usually understood others. The following accuracy concerns were identified: a. Review of section C showed the resident was interviewable. The resident participated in the BIMS, but the results of the interview were overridden and entered as 99 (unable to complete interview) a staff assessment for mental status was conducted instead. Review of the BIMS showed the accurate score would be 6 out of 15. b. Review of section D showed the resident mood interview should not be conducted and was coded as "No (resident is rarely/never understood)." This resulted in the resident not being asked any questions for the mood assessment. A staff interview of the resident's mood was conducted in its place. c. During an interview on 7/18/19 at 9:40 AM, the social worker acknowledged the coding of sections C and D of the MDS assessments. She stated staff interviews should be done if the assessed individual was unable to answer at least 4 of the questions in the BIMS assessment. When the social worker was asked about the coding for Section D she stated her understanding was the mood assessment should be conducted with staff due to the BIMS score of 99 in Section C.	F 641	to the new RAI manual rules. The social worker will attempt to conduct the interview with ALL residents, the social worker will choose no on the assessment, if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available, otherwise, the resident will be interviewed both cognitively and for mood. Staff assessment will be conducted only if the mental status of the resident meets the criteria for a staff interview as defined above and in RAI manual. 3.Social worker will adhere to the RAI manual for administration of social service assessments. Social worker will adhere to future changes of RAI manual and remain informed of changes. The SSW will conduct an audit of BIMs interviews will be completed for 1 quarter to ensure that the practice has changed and has become a standard practice. 4.The audits will be presented at the monthly QAPI meeting for review and continued compliance.	

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F 641	Continued From page 16	F 641		

3. Interview with the MDS coordinator on 7/18/19 at 12:15 PM revealed a new program was being used to complete the assessments. She stated further education to ensure the BIMS score was being accurately reflected on the assessments may be needed.

4. According to CMS's MDS 3.0 RAI Manual, page C-16 "Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15. If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and a staff assessment is completed.
To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips on page C-4 for residents who choose not to participate at all.
Code 99, unable to complete interview: if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a dash.
Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items."

5. According to CMS's MDS 3.0 RAI Manual, page D-1 and D-2: "Obtaining information about

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F 641	Continued From page 17 mood directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying a mood disorder ...Code 0, no: if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©)."	F 641		
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 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	F 645		8/28/19

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F 645	Continued From page 18	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 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 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

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F 645	Continued From page 19 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 a pre-admission screening and resident review (PASARR) was completed timely for 2 of 3 sample residents (#10, #24) reviewed for this area. The findings were: 1. Review of the medical record for resident #10 showed the resident was admitted to the facility on 1/24/19, and a PASARR level 1 was completed after admission on 2/7/19. Review of the level 1 showed a PASARR level 2 was to be completed based on a mental disorder diagnosis. The following concerns were identified: a. Review of the PASARR 2 showed it was completed after admission on 3/18/19; however, the facility placement was determined to be appropriate with no specialized services recommended. b. Interview with administrative assistant #1 on 7/18/19 at 9:35 AM confirmed the assessments were completed after admission. She stated there were times when a resident required placement and the required timing of the reviews could not be met. 2. Review of the PASARR 1 for resident #24 showed the review was completed on 2/15/19, which was also the date of admission. The results of the level 1 required a level 2 to be completed. Review of the PASARR 2 showed it was completed on 3/19/19. The facility placement was found to be appropriate with no specialized services required. Interview with administrative assistant #1 on 7/18/19 at 9:35 AM confirmed the level 2 assessment was completed after	F 645	1.A review of admissions since 7/18/19 was completed and found that there were no PASARR level 2 triggered prior to admission. 2.The PASARR Level 1will be completed on all admissions prior to admission. 3.An educational letter is being sent out by the Administrator or designee to all Cody Regional Health providers and case management informing them of the requirements of F-645 and that no resident will be admitted until the PASARR 1 is completed and that if a PASARR 2 is triggered that the resident will not be admitted until approval from the state is received. Education was provided to the facility admission staff as well as the IDT team members as to the PASARR requirements. 4.The Administrator or designee will complete a monthly audit of all admissions to ensure that the PASARR Level 1 was completed prior to admission and that any resident that triggered a PASARR 2 was not admitted until approval from the state was received. These audits will be presented at the monthly QAPI meetings. The audits will continue to ensure 100% compliance.	

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F 645	Continued From page 20 admission.	F 645		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents received treatment and services to promote healing for 2 of 5 sample residents (#16, #27) with pressure ulcers. The following concerns were identified: 1. Review of the quarterly MDS assessment dated 4/24/19 showed resident #16 had diagnoses which included other fracture, non-Alzheimer's dementia, and depression. Further, the resident required limited assistance of 1 person for bed mobility, transfer, dressing, toilet use, and personal hygiene, was determined not at risk of developing pressure ulcers, and had a stage 2 pressure ulcer. Review of the care plan last revised on 4/1/19 showed, "The resident has a stage 2 pressure ulcer left posterior ankle. [sic]	F 686	1.Residents #16 and #27 pressure ulcer will be assessed weekly by the skin nurse/designee until resolved. The Assessment will include measurements of length, width and depth where possible, status of wound perimeter, wound bed and healing progress, and report improvements and declines to the MD, any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, stage of wound. Resident # 16 has been seen by the Wound Care Center Physician and new orders for wound care obtained. 2.Current residents will be assessed for pressure ulcers and residents known to have pressure ulcers will be assessed	8/21/19

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F 686	Continued From page 21 or potential for pressure ulcer development r/t [related to] immobility" and interventions included "...Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD..." The following concerns were identified: a. Observation on 7/17/19 at 10:04 AM showed the resident had a circular area on his/her left ankle which was white in the center and red around the edges. b. Review of the "Skin/Wound" notes between 1/3/19 and 6/21/19 showed the wound measured 2 cm (centimeters) by 2 cm on 1/3/19 and no further wound measurements were documented. c. Review of the "Skin Observation Tool" assessments showed there were no documented wound measurements for 18 days between 1/11/19 and 1/29/19, 23 days between 1/29/19 and 2/21/19, 12 days between 2/27/19 and 3/11/19, 19 days between 3/15/19 and 4/3/19, 20 days between 4/3/19 and 4/23/19, 16 days between 4/29/19 and 5/15/19, 23 days between 5/15/19 and 6/7/19, and 12 days between 6/27/19 and 7/9/19. 2. Review of the admission MDS assessment dated 5/6/19 showed resident #27 had diagnoses which included hip fracture and depression. Further, the resident required extensive physical assistance of 2 or more people for bed mobility, transfer, and toilet use, extensive physical assistance of 1 person for dressing and personal hygiene, was at risk for developing pressure ulcers, and had an unstageable pressure ulcer. Review of the care plan last revised on 6/28/19 showed "The resident has bilateral suspected	F 686	weekly by the skin nurse/designee until resolved. The Assessment will include measurements of length, width and depth where possible, status of wound perimeter, wound bed and healing progress, and report improvements and declines to the MD, any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, stage of wound. 3.A)The skin nurse/designee will assess all residents' skin upon admission and weekly to determine appropriate care and initiate interventions to treat/prevent skin issues. Physician notification and orders will be obtained and the Care Plan and Kardex will be completed/updated. B)The Skin nurse/designee will present all identified skin issues, including pressure ulcers, residents at risk for skin issues, data for review weekly at the Skin Meeting, attended by the DON, Infection Preventionist, Nurse Manager, Dietician and/or designee. 4.The Skin nurse/designee will present the Skin issue data, including pressure ulcers, at the QAPI for review.	

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F 686	Continued From page 22	F 686		

deep tissue injuries with open areas on heels and potential for new pressure ulcer development r/t [related to] immobility and edema" and interventions included "Assess/record/monitor wound healing measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the MD...Monitor/document/report PRN [as needed] any changes in skin status: appearance, color, wound healing, s/sx [signs and symptoms] of infection, wound size (length X width X depth), stage..." The following concerns were identified:

a. Observation on 7/17/19 at 10:10 AM showed the resident had bilateral wounds to his/her heels which appeared to be a dried dark blister.

b. Review of the "Skin/Wound" notes between 4/30/19 and 7/16/19 showed the left heel wound measured 4.2 cm by 5.4 cm and the right heel wound measured 8.8 cm by 6.3 cm on 4/30/19 and no further wound measurements were documented.

c. Review of the "Skin Observation Tool" assessments showed there were no wound measurements for 70 days between 4/30/19 and 7/9/19.

3. Interview with the wound nurse on 7/18/19 revealed she usually documented wound measurements and healing weekly or twice per week. Further she confirmed the facility could not determine treatment effectiveness and wound healing if wound assessments were not completed.

4. Review of the policy titled "Wound Care" last revised on 3/12 showed "...all patients admitted to the facility shall receive a complete head-to-toe

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	535027	A. BUILDING _____ B. WING _____	C 07/18/2019

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F 686	Continued From page 23 assessment, at which time a thorough examination of the skin will be done. The assessment of the care or treatment needs of the patient will be ongoing throughout the patient and/or resident stay..."	F 686		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure bed rails were assessed for safety for 3 of 3 sample residents (#16, #33, #67) with bed rails. The findings were:	F 700	1.A new assessment was completed for residents #16, #33 and #67. The siderails for residents # 16 and #33 were removed. The assessment will include risk of entrapment as well as an indication for use.	8/28/19

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F 700	Continued From page 24 1. Review of the quarterly MDS assessment dated 4/24/19 showed resident #16 had diagnoses which included other fracture, non-Alzheimer's dementia, and depression. Further, the resident required limited assistance of 1 person for bed mobility, transfer, dressing, toilet use, and personal hygiene, was determined not at risk of developing pressure ulcers, and had a stage 2 pressure ulcer. The following concerns were identified: a. Observation on 7/16/19 at 10:19 AM showed the resident had bilateral side rails to the upper portion of his/her bed which were designed to have 4 gaps and the side rails were covered. Observation on 7/18/19 at 8:25 AM showed the resident had bilateral side rails to the upper portion of his/her bed and a side rail to the lower right side of the bed. The lower side rail was designed with 2 gaps which measured 8 inches by 5 inches and 2 gaps which measured 2 1/2 inches by 3 1/2 inches. b. Review of the "Comprehensive Side Rail Assessment" dated 10/26/16 showed there was no evidence the resident was assessed for entrapment risk and it was indicated the right side should be up and covered and the left side should be "zip tied down." There was no evidence the resident or device was assessed for entrapment risk and the device was not indicated for use. c. Interview with nursing supervisor #1 on 7/18/19 at 10:30 AM revealed the resident was only required to have 1 side rail in use. 2. Review of the quarterly MDS assessment dated 5/9/19 showed resident #33 had a BIMS score which was not completed and a staff assessment which showed his/her short-term memory and long-term memory were ok. Further review showed the resident had diagnoses which	F 700	2.An entire review of all beds has been completed. On some of the beds the siderails cannot be removed without disconnecting the electrical function of the bed. Any resident that has an indication for siderail use will be assessed for indication of use, entrapment, and whether or not the side rail is the appropriate device to use. Any siderail that cannot be removed that is not indicated for use will be fastened securely in the down position so that it cannot be used without proper assessment. Siderails that are not indicated for use and can be removed will be removed. 3.Monthly audits and Re-assessment for side rail use will be conducted by the DON or designee according to facility policy. Education for all staff concerning side rail assessment and entrapment was provided at the monthly all staff meeting (8/21/19) and via “Go to Meeting” for those that could not attend in person. 4.Monthly audits of side rails in use, indication of use, entrapment assessment and determination of alternatives will be reviewed at the monthly QAPI meeting for continued compliance.	

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F 700	Continued From page 25	F 700		

included osteoarthritis of the knee, morbid obesity, spondylosis (degenerative changes in the spine), and spinal stenosis, required supervision with set up help for bed mobility, transfer, toileting, dressing, and personal hygiene, and was at risk for falls. The following concerns were identified:

a. Observation on 7/16/19 at 9:44 AM showed the resident had a side rail to the upper left portion of his/her bed and the other side of the bed was against the wall. The side rail was designed to have 2 gaps which measured 7 3/4 inches by 5 1/2 inches and 2 gaps which measured 2 1/2 inches by 7 1/2 inches.

b. Review of the "Comprehensive Side Rail Assessment" dated 10/26/16 showed there was no evidence the resident or device was assessed for entrapment risk.

3. Review of the quarterly MDS assessment dated 6/17/19 showed resident #67 had a BIMS score of 9 out of 15 (mild cognitive impairment) and diagnoses which included cerebrovascular accident, transient ischemic attack, or stroke, hemiplegia or hemiparesis, and seizure disorder or epilepsy. Further review showed the resident required extensive assistance of 2 or more people for bed mobility, dressing, and personal hygiene and total assistance of 2 or more people for transfer and toilet use. The following concerns were identified:

a. Observation on 7/18/19 at 8:23 AM showed the resident had side rails to the bilateral upper portion of his/her bed which were designed to have 2 gaps which measured 7 3/4 inches by 5 1/2 inches and 2 gaps which measured 2 1/2 inches by 7 1/2 inches.

b. Review of the "Summary of Findings" dated 8/2/18 showed the resident had bilateral

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F 700	Continued From page 26 side rails to serve as an enabler and were indicated for use. Further review showed showed there was no evidence the resident or devices was assessed for entrapment risk. 4. Interview with nursing supervisor #1 on 7/18/19 at 10:30 AM revealed the facility only completed reassessment of side rails if the bed was changed and confirmed the side rail assessment did not include entrapment risk.	F 700		