STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 02/10/2020

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 1/28/20 to 2/10/20. The survey was prompted by complaint intakes WY00002921, WY00002958, WY00002995, WY00003005, WY00003008 and WY00003014. The following common abbreviations are used through this document: DON: Director of Nursing RN: Registered Nurse CNA: Certified Nursing Assistant MDS: Minimum Data Set ADL: Activities of Daily Living QAPI: Quality Assurance Performance Improvement Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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;	F 645		3/6/20

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

Electronically Signed | 03/05/2020

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 645	Continued From page 1 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 facility services.	F 645		

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F 645	Continued From page 2 §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 a Preadmission Screening and Resident Review (PASARR) level I & II was performed for 1 of 3 sample residents (#3) with a qualifying diagnosis. The findings were: Review of the medical record for resident #3 showed the resident was admitted to the facility on 10/30/19. Review of a PASARR I completed on 10/30/19 showed the resident had diagnoses which included bipolar disorder and major depression. Further review showed the resident received a categorical 6 determination (categorically appropriate for convalescent stay, not to exceed 120 day) and a PASARR II was not completed at that time. Review of a PASARR I dated 11/13/19 showed the resident had diagnoses which included major depression and alcohol dependence. Further review showed the resident was referred to level II for evaluation of mental illness. However, further review of the medical record showed no evidence that level II evaluation was completed. Review of a PASARR I dated 1/8/20 showed the resident had diagnoses which included major depression and	F 645	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility□s allegation of compliance. F 645 PASRR Screens CORRECTIVE ACTION Resident #3 no longer resides in the facility. IDENTIFICATION OF OTHERS An audit was conducted by the social workers on 2/28/20 with a representative who receives the Level I PASRR Screens	

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F 645	Continued From page 3 alcohol dependence. Further review showed the resident was referred to level II for evaluation of mental illness. Review of a PASARR level II determination summary report dated 1/9/20 showed the initial date of request was 1/8/20. Further review of the level II determination showed the resident had been at the facility since 10/30/19 and "Per the facility, the admitting PASRR (sic) Level I did not trigger for a PASRR (sic) Level II or a Categorical 6 determination; however, this request was submitted to Optum under the basis of an expiring categorical as it is now determined that the patient will require long-term care" and "...a PASRR level I was completed upon admission that triggered a categorical 6, although it was never sent or received by Optum at the time of admission..." Interview with the social services assistant on 1/31/20 at 8:45 AM revealed she was unsure why a PASARR II had not been completed or identified and she was unable to provide evidence of the submission for the PASARRs the facility completed for the resident.	F 645	to ensure that all current residents admitted in the last 4 months have the appropriate PASRR I Screen. No current residents were identified as not having a Level I screen. The Social workers also audited all residents requiring a PASRR Level II screen on 2/28/20. All residents requiring PASRR Level II Screens have had them or have one in process in the appropriate time frame. SYSTEMIC CHANGE Information for the Level I PASRR Screen is entered into the electronic PASRR system by the admissions staff prior to admission and a determination is received and printed, and then it is submitted electronically. The electronic PASRR system does not allow for a verification of a successful submission, therefore, the admission□s staff prints the submission page, writes the resident□s name, date and time of submission and signs the page as verification that the PASRR was submitted. The social service team follows up on any additional PASRR Level II requirements if needed based on the determination from the PASRR Level I within the required time frame. The social worker tracks the dates of the determination for prompt submission of the Level II if needed. Education was provided to the Admissions staff and Social Service staff regarding submission and receipt of verification of	

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F 645	Continued From page 4	F 645	submission by the NHA prior to 3/6/20. MONITORING The social worker verifies submission of each PASRR Level I Screen via the signed submission page and files it with the Level I determination form, and monitors the timely submission of the required Level II□s. The Level I and Level II submissions are tracked and any identified patterns or trends are reported to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
F 677 SS=E	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 medical record review, resident and staff interview, review of facility grievances, review of bathing documentation, and review of QAPI information, the facility failed to ensure 7 of 10 sample residents (#1, #2, #4, #5, #6, #15, #18) who required assistance with bathing were provided assistance as required. The findings were: 1. Review of the quarterly MDS assessment dated 10/28/19 showed resident #15 had a brief	F 677	F 677 ADL Care Provided CORRECTIVE ACTION Based on the shower audit conducted on 2/27/20 showers were provided to resident # 15 on 2/25/20, #18 on 2/24/20, #2 on 2/27/20, #6 on 2/25/20, #1 on 2/26/20 , #4 no longer resides in the	3/6/20

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F 677	Continued From page 5 interview for mental status (BIMS) score of 15 (cognitively intact), required extensive physical assistance of 2 or more people for bed mobility, transfers, dressing, toilet use, and personal hygiene, and required total physical assistance of 1 person for bathing. The following concerns were identified: a. Interview with the resident on 1/30/20 at 3:09 PM revealed his/her shower days were Tuesday and Friday and the only time s/he refused a shower was if s/he didn't feel well or had something else going on. Further interview with the resident revealed since the facility got rid of shower aides, s/he was unsure when s/he would get his/her next shower. b. Review of a "Concern Form" dated 1/17/20 showed the resident reported s/he wanted his/her baths on Tuesday and Friday morning and CNAs had told him/her s/he was not on the list. Further review showed the form was completed on 1/24/20 and actions taken were "Resident was scheduled for [his/her] showers on Tuesday and Friday mornings and staff will try to accommodate the times when appropriately staffed." c. Review of the ADL documentation for 1/1/20 through 1/28/20 showed the resident only received a shower/bath on 1/28/20. 2. Review of the admission MDS assessment dated 1/10/20 showed resident #18 had a BIMS score of 15 (cognitively intact), required limited physical assistance of 1 person for bed mobility, required extensive physical assistance of 1 person for transfers, dressing, toilet use, and personal hygiene, and was independent for bathing. The following concerns were identified: a. Interview with the resident on 1/30/20 at 3:22 PM revealed the resident's last shower was 1/29/20, s/he didn't know what days his/her	F 677	facility and #5 on 2/25/20. IDENTIFICATION OF OTHERS An audit was conducted by the Unit Managers 2/27/20 of all facility residents looking back 14 days to identify when they were bathed last. Any resident identified as not having bathed in the last week was offered a shower/bath and their response documented as to acceptance or declination. SYSTEMIC CHANGE In-service education was provided to the nursing staff as to the requirement of bathing residents and documentation of acceptance or declination. This education was completed by 3/6/20. C.N.A. staff is assigned to bath identified residents daily. The Unit Managers review the bath list and bathing documentation 5 days per week to ensure that all residents have been offered a bath/shower as scheduled and that the event has been properly documented. If a bathing opportunity is missed it is rescheduled and put back on the bath list. The Unit Managers address any identified concerns related to bathing with the appropriate staff and inform the Director of Nursing. MONITORING The Director of Nursing reports any identified patterns related to missed	

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F 677	Continued From page 6 showers were scheduled for, and s/he had to ask for "weeks" to get a shower. Further interview revealed the resident had refused a shower one time because it was very cold and s/he had been "begging" for a shower ever since then. b. Review of a "Concern Form" dated 1/15/20 showed the resident "does not like [his/her] shower days were changed/ Prefers them to remain the same days they were previously and likes them between AM smoke break and lunch." Further review showed the form was completed on 1/15/20 and the action taken was "Spoke w/ [with] lead RCS [Resident Care Specialist] to change back to original schedule. Wednesday & Fridays." c. Review of the ADL documentation for 1/1/20 through 1/28/20 showed the resident did not have a shower or bath recorded. 3. Review of the quarterly MDS assessment dated 12/27/19 showed resident #2 had a BIMS score of 15 (cognitively intact), required extensive physical assistance of 1 person for bed mobility, dressing, toilet use, and personal hygiene, required extensive physical assistance of 2 or more people for transfers, and bathing did not occur. The following concerns were identified: a. Interview with the resident on 1/30/20 at 3:40 PM revealed his/her shower days were on Wednesday and Saturday; however, s/he only received showers on Wednesdays. Further interview revealed the resident only received her scheduled showers when a specific CNA worked. b. Review of the ADL documentation for 1/1/20 through 1/28/20 showed the resident only received a shower/bath on 1/2/20. 4. Review of the quarterly MDS assessment dated 1/2/20 showed resident #6 had a BIMS	F 677	bathing to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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F 677	Continued From page 7 score of 15 (cognitively intact) and required extensive physical assistance of 1 person for bed mobility, transfers, toilet use, dressing, personal hygiene and bathing. The following concerns were identified: a. Review of the resident's ADL care plan last revised on 1/8/20 showed the resident required extensive assistance of 1 person for bathing. There was no documentation related to the frequency the resident was to receive showers or baths. b. Review of the ADL documentation for 1/1/20 through 1/28/20 showed the resident did not have a shower or bath recorded. Review of the ADL documentation for December 2019 showed the resident did not have a shower or bath recorded. Review of the ADL documentation for November 2019 showed the resident received a shower/bath on 11/13/19. 5. Review of the significant change MDS assessment dated 11/26/19 showed resident #1 had a BIMS score of 14 (cognitively intact), required extensive physical assistance of 2 or more people for bed mobility, transfers, dressing, and toilet use, required extensive physical assistance of 1 person for personal hygiene, and bathing did not occur during the look back period. The following concerns were identified: a. Review of the resident's ADL care plan last revised on 3/7/19 showed the resident was totally dependent on 2 staff for bathing twice per week and as necessary. b. Review of the ADL documentation for 1/1/20 through 1/28/20 showed the resident received a shower/bath on 1/7/20, 1/15/20, 1/22/20, and 1/25/20. Review of the ADL documentation for December 2019 showed the resident received a shower/bath on 12/3/19 and	F 677		

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F 677	Continued From page 8 12/10/19. Review of the ADL documentation for November 2019 showed the resident received a shower on 11/5/19 and 11/12/19. 6. Review of the admission MDS assessment dated 11/6/19 showed resident #4 had a BIMS score of 10 (moderately cognitively impaired), required extensive physical assistance of 1 person for bed mobility, transfers, dressing, and toilet use, and total physical assistance of 1 person bathing. The following concerns were identified: a. Review of the resident's ADL care plan last revised on 1/8/20 showed no bathing dates or frequency was identified on the care plan. b. Review of the ADL documentation for 1/1/20 through 1/28/20 showed the resident only received a shower/bath on 1/21/20. Review of the ADL documentation for December 2019 showed the resident did not have a shower or bath recorded. Review of the ADL documentation for November 2019 showed the resident received a shower or bath on 11/1/19 and 11/29/19 and there were no other recorded showers or baths for the month. 7. Review of the quarterly MDS assessment dated 10/28/19 showed resident #5 had a BIMS score of 15 (cognitively intact), required extensive physical assistance of 2 or more people for bed mobility, transfers, dressing, and toilet use, required extensive physical assistance of 1 person for personal hygiene, and bathing did not occur. The following concerns were identified: a. Review of the resident's ADL care plan last revised on 8/12/19 showed the resident preferred to shower twice per week. Further review showed the resident required extensive assistance of 1 person for bathing.	F 677		

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F 677	Continued From page 9 b. Review of the ADL documentation for 1/1/20 through 1/28/20 showed the resident did not have a shower or bath recorded recorded. Review of the ADL documentation for December 2019 showed the resident received a shower/bath on 12/3/19, 12/10/19, and 12/24/19. Review of ADL documentation for November 2019 showed the resident received a shower/bath on 11/12/19. 8. Interview with the administrator and DON on 1/30/20 at 9:48 AM revealed the facility identified a problem with bathing on 1/29/20 and created a performance improvement plan. Further interview revealed the facility had changed the staffing model at the beginning of January, the bath aides were removed, and showers were assigned to floor staff. The model was effective for "a little while" and the facility determined it was no longer effective. 9. Review of an "Ad Hoc QAPI Meeting Agenda/Summary" dated 1/29/20 showed the opportunity for improvement was "consistent bathing" and "improving bathing process." Identified area was "Missed Showers" and the corrective action was "Schedule a shower for residents identified as not having a shower in the last 7 days."	F 677		