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| | 535038 | A. BUILDING _____ B. WING _____ | 05/13/2021 |

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| ROCKY MOUNTAIN CARE - EVANSTON | 475 YELLOW CREEK ROAD EVANSTON, WY 82930 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by Healthcare Licensing and Surveys from 5/10/21 to 5/13/21.<br><br>The following common abbreviations are used throughout this document:<br><br>DON: Director of Nursing<br>CNA: Certified Nursing Assistant<br>MDS: Minimum Data Set<br>RN: Registered Nurse<br>ADON: Assistant Director of Nursing<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 554 SS=E | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, medical record review, policy and procedure review, and clinical standard of practice review, the facility failed to ensure medications were safely administered for 3 of 3 sample residents (#1, #19, #34) reviewed for self-administration of medications. The findings were:<br><br>1. Review of the care plan, last revised on 3/1/21, showed resident #34 was admitted to the facility on 11/10/21 with diagnoses which included unspecified dementia with behavioral disturbance, muscle weakness (generalized), | F 554 | Resident #34 was reassessed for self-administration of meds on 06/03/21. Resident was found unable to administer own medication.<br><br>Resident #1 was reassessed for self-administration of meds on 06/03/21. Resident was found unable to administer own medication.<br><br>Resident #19 was reassessed for self-administration of meds on 06/03/21. Resident was found able to administer | 6/16/21 |

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

Electronically Signed | 06/14/2021

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| F 554 | Continued From page 1<br>encounter for palliative care, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. Further review showed interventions which included "Medication administered/monitored by LN [licensed nurse] as ordered." The following concerns were identified:<br>a. Observation on 5/10/21 at 5:12 PM showed resident #34 was in the dining area seated at a table, with his/her head down on top of his/her arms crossed in front of him/her. RN #1 approached the resident with a small cup of medications in pill form. RN #1 touched the resident on the shoulder, which startled the resident, and told the resident she had medications for him/her. The resident nodded in acknowledgement and put his/her head back down onto his arms resting on the table. The nurse placed the cup next to the resident's right elbow and left the dining room. Further observation showed the resident did not take the medications until his/her meal arrived at 5:18 PM, without the nurse present.<br>b. Review of the "Self-Administration of Medication" assessment dated 1/22/21 and timed 3:47 PM showed the resident did not want to self-administer medications and the resident's decision making ability was "Severely impaired - Never/rarely makes decisions."<br><br>2. Review of the care plan, last revised on 4/18/21, showed resident #1 was admitted to the facility on 1/10/21 with diagnoses which included unspecified dementia with behavioral disturbance, generalized anxiety disorder, insomnia, other chronic pain, and chronic obstructive pulmonary disease. Further review showed interventions which included "My medication will be administered and monitored by LN as ordered." The following concerns were | F 554 | own medication. Care plan was updated on 06/03/21 to reflect this change. Resident #19 will be reassessed for this per the quarterly assessment schedule and upon any significant change in condition.<br><br>All residents in the facility will be assessed for self-administration of medication on/before 6/16/2021. Any resident who is determined able to self-administer meds will have care plan updated and will be reassessed per the quarterly assessment schedule and upon any change in condition.<br><br>All nursing staff will be educated on/before 6/16/2021 regarding the self-administration of meds to residents.<br><br>Audits will be completed by the DON or designee weekly for 4 weeks and monthly for 3 months thereafter. Any issues identified during the audits will be corrected and shared with the QAPI committee. | |

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| F 554 | Continued From page 2<br>identified:<br>a. Observation on 5/10/21 at 5:09 PM showed resident #1 was seated at a table in the dining room waiting for his/her meal. RN #1 approached the resident with a small cup of medications in pill form. The nurse acknowledged the resident, stated she had medications for him/her, set them on the table, and left the dining area. The resident took a few sips of water, and then took the medications, without the nurse present.<br>b. Review of the "Self-Administration of Medication" assessment dated 1/11/21 and timed 1:20 PM showed the resident did not want to self-administer medications.<br><br>4. Review of the care plan, last revised on 5/3/21, showed resident #19 was admitted to the facility on 12/11/18 and had diagnoses which included sequelae [a condition which is the consequence of a previous disease or injury] of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and major depressive disorder. Further review showed interventions which included "My medication is to be administered and monitored by LN as ordered." The following concerns were identified:<br>a. Observation on 5/12/21 at 5:03 PM showed RN #2 placed metformin and acidophilus in a medication cup, entered the resident's room, set the medications on the tray table, and left the room. Continued observation showed the resident took the medications, without the nurse present, at 5:28 PM.<br>b. Interview with RN #2 on 5/13/21 at 8:48 AM revealed she left medications at the bedside for residents who were alert and did not have | F 554 | | |

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| F 554 | Continued From page 3<br>swallowing issues.<br>c. Review of the medical record showed no evidence a self-administration of medication assessment was completed.<br>d. Interview with the administrator on 5/13/21 at 11:22 AM revealed the facility did not have a self-administration assessment completed for the resident.<br><br>5. Interview with the DON on 5/13/21 at 9:37 AM revealed nurses were expected to stay with residents during medication administration to ensure medications were taken and medications should not be left at the bedside for any residents.<br><br>6. Review of the policy titled "Medication Pass Protocol" last revised 1/19/18 showed "...16. Should a resident be away from his or her room, or unavailable during the medication pass, the medication should be labeled with the name of the resident, the time of administration, and stored in the medication cart until the resident can be located for administration. 17. Self administration of drugs is permitted when the resident is able to successfully pass the Self Administration Assessment, an order is obtained by the physician and proper storage of medications is provided..."<br><br>7. According to Griffin-Perry, Potter, and Ostendorf in "Nursing Interventions & Clinical Skills", 7th edition, 2020, safe and accurate steps in medication administration should include " ... Evaluate the patient's knowledge of the medication, and provide appropriate teaching using teach-back technique. 3. Stay with the patient until the medication is taken. Provide assistance as necessary. Do not leave | F 554 | | |

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| F 554 | Continued From page 4<br>medication without a health care provider's order at the bedside. 4. Respect the patient's right to refuse medication ... When medication is refused, determine the reason for this and take action accordingly." Post-administration activities should include "1. Properly document medications administered. 2. Document data pertinent to a patient's response ... Include the ability of patient and family caregiver to teach back the education provided. 3. If a medication is refused, document that it was not given, the reason for the refusal, and when the health care provider was notified." Special considerations when administering medications include age, especially "Individuals older than age 65 ... Because of the physiological changes associated with aging, nursing interventions are needed to promote safe and effective medication administration ..." | F 554 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, and medical record review, the facility failed to ensure physician orders were implemented for 1 of 1 sample residents (#23) with a communication deficit. The findings were: | F 684 | Resident #23 was evaluated by speech therapist on 5/12/2021. Resident #23 refused to participate in speech therapy services at that time.<br><br>Resident #23 was given communication | 6/16/21 |

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| F 684 | Continued From page 5<br>1. Review of the significant change MDS assessment dated 4/21/21 showed resident #23 readmitted to the facility on 4/15/21 and had diagnoses which included mild intellectual disabilities, dysphagia following cerebral infarction, and unspecified sequelae of cerebral infarction. Further review showed the resident had a brief interview for mental status score of 6 out 15, which indicated the resident had severe cognitive impairment, and was coded as having "unclear speech-slurred or mumbled words." Review of the "Communication" care plan last revised on 4/18/21 showed "I have difficulty making myself understood at times R/T [related to] slurred or mumbled words when communicating and at time [sic] my focus move [sic] to a different task" and interventions included "Ask resident to repeat slurred, mumbled words as needed to complete communication... Disregard inappropriate words when I'm conversing... Encourage me to communicate and redirect me back on task as needed when expressing self... Praise me when spoken words are distinct and intelligible... Provide a quiet, non-hurried environment, free of background noises and distractions... Remind resident to speak slowly and clearly... Repeat what the resident has said to validate as or [sic] if needed..." The following concerns were identified:<br>a. Observation on 5/11/21 at 8:37 AM showed the resident had difficulty with speaking. Interview at that time revealed the resident had slurred and mumbled speech which was difficult to understand.<br>b. Interview with speech therapist #1 on 5/12/21 at 5:40 PM revealed the resident had previously received speech therapy services related to swallowing, speaking, and staff's difficulty understanding the resident. During the | F 684 | board on 05/17/21 and educated on the use of the communication board. Resident has been using this board intermittently to communicate with staff.<br><br>New Director of Rehab (DOR) started on 5/15/2021. DOR was in-serviced on/before 6/16/2021 regarding the follow-up and carry-out of MD orders for all therapy disciplines.<br><br>DOR or designee will audit all existing resident orders and all new admissions from 5/1/2021 to current to ensure all MD orders have been carried out.<br><br>DOR will audit new admissions and new orders once/week for 4 weeks and once/month for 3 months thereafter. Any issues identified during the audits will be corrected immediately and will be brought to the QAPI committee. | |

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| F 684 | Continued From page 6<br>speech therapy, the resident was agreeable to using a communication board; however, s/he was discharged from the facility prior to implementation. Further interview revealed the resident did not receive speech therapy orders upon return to the facility and s/he was not on speech therapy case load at that time.<br>c. Review of re-admission orders dated 4/15/21 showed the resident had orders for speech therapy evaluation and treatment.<br>d. Interview with the administrator on 5/12/21 at 6:22 PM confirmed the facility did receive orders for speech therapy at the time of re-admission. Further interview revealed the resident was evaluated on 5/12/21 and refused to participate in speech therapy; however, the administrator confirmed the resident should have received the evaluation at the time of re-admission. | F 684 | | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>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.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§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. | F 700 | | 6/16/21 |

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| F 700 | Continued From page 7<br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure bed rails were assessed for 1 of 2 sample residents (#23) with bed rails. The findings were:<br><br>1. Review of the significant change MDS assessment dated 4/21/21 showed resident #23 readmitted to the facility on 4/15/21 and had diagnoses which included mild intellectual abilities, dysphagia following cerebral infarction, and unspecified sequelae of cerebral infarction. Further review showed the resident had a brief interview for mental status score of 6 out 15, which indicated the resident had severe cognitive impairment, and the resident required extensive physical assistance of 1 person with most activities of daily living. The following concerns were identified:<br>a. Observation on 5/10/21 at 4:14 PM showed the resident's bed had an enabler bar on the upper right side of the bed.<br>b. Observation on 5/13/21 at 11:15 AM showed the enabler bar remained to the upper right side of the resident's bed. The enabler bar was an upside down U shape, was secured to the bed frame at the bottom, and was rounded at the top which created a gap in the middle. The gap measured 9 1/4 inches long from the top of the bar to the top of the mattress by 3 3/4 inches wide. | F 700 | A bed rail assessment was completed for resident #23 on 05/12/21. It was determined the resident uses the rail for mobility and transfers. Resident care plan was updated on 05/12/21 to reflect the use of the bed rail.<br><br>All residents will be assessed for bed rail usage and appropriateness of bed rails on/before 6/16/2021. Any resident found to be at risk for use of bed rails will be addressed appropriately.<br><br>Audits of bed rails in use in the facility will be conducted on a weekly basis by the maintenance staff. This audit will be shared with the nursing department who will ensure proper assessment, documentation and care planning. Issues identified during the audit will be shared with the QAPI committee.<br><br>All clinical staff will be educated regarding the use of bed rails on/before 6/16/2021. | |

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| F 700 | Continued From page 8<br>c. Review of a Fall Risk assessment completed on 3/17/21 showed the resident had a score of 23 and indicated the resident was at a high risk for falls.<br>d. Review of the medical record showed no evidence a bed rail assessment was completed for the resident.<br>e. Interview with the administrator and ADON on 5/12/21 at 2:43 revealed the resident switched rooms and the enabler bar was already attached to the bed. The facility did not identify the enabler bar at the time of the move. Further interview confirmed a bed rail assessment was not completed for the enabler bar.<br><br>2. Review of the "Restraint Protocol" provided by the facility on 5/13/21 showed "...1. The facility will assess for all potential restraints [sic] examples include: lipped mattresses, bed canes, side rails, geri chairs, lap buddy, alarms etc..." | F 700 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | F 812 | | 6/16/21 |

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| F 812 | Continued From page 9<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and policy and procedure review, the facility failed to ensure food was served in sanitary conditions during 1 of 2 meal observations. The census was 44. The findings were:<br><br>1. Observation on 5/12/21 at 11:32 AM showed dietary aide #1 opened the ice machine lid with gloved hands. The dietary aid grabbed a plastic cup, while wearing the same gloves used to open the lid, scooped ice into the cup from the ice machine, and dumped the ice into separate plastic cups on a cart next to the machine. After filling all of the larger cups on the cart, the staff member grabbed two smaller cups, one in each hand, and scooped ice into the cups. The dietary aide's gloved hands contacted the ice in the machine each time he scooped ice into the cups. After adding ice to all the cups, the dietary aid filled all of the cups with water for the residents.<br><br>2. Interview with the dietary manager on 5/12/21 at 2:55 PM revealed the dietary aid should have removed gloves, washed hands, and applied clean gloves after opening the ice machine door to prevent cross contamination from occurring.<br><br>3. Review of the policy titled "Infection Control-Standard precautions" last revised 7/1/19 showed "...a. Wear gloves (clean, non-sterile) when touching blood, body fluids, secretions, excretions, and contaminated items...c. Remove gloves promptly after use, before touching | F 812 | Dietary staff education was completed on/before 6/16/2021. Staff educated on the proper procedure for hand hygiene and for prevention of cross contamination. Special education took place regarding the ice machine and the procedure for filling cups with ice.<br><br>Dietary manager or designee will complete audit of hand hygiene and use of the ice machine weekly for 4 weeks and monthly for 3 months. Any issues will be addressed immediately and will be reported to the QAPI committee. | |

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| F 812 | Continued From page 10<br>noncontaminated items and environmental surfaces, and before going to another resident, and wash hands...." | F 812 | | |