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	53A051	A. BUILDING _____ B. WING _____	11/04/2021

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 11/1/21 to 11/4/21. The following common abbreviations are used throughout this document: DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		11/30/21

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

Electronically Signed | 11/28/2021

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F 636	Continued From page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the Resident Assessment	F 636	- Unable to go back and correct late submission of MDS's. SLNC has already	

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F 636	Continued From page 2 Instrument User's Manual, the facility failed to ensure the admission and/or annual MDS assessment was completed timely for 1 of 6 sample residents (#72). In addition, the facility failed to ensure care area assessments (CAAs) were completed for 2 of 6 sample residents (#17, #72). The findings were: 1. Review of the admission MDS assessment for resident #72 showed an assessment reference date (ARD) of 10/14/21. The assessment indicated the resident was admitted on 9/30/21. However, further review showed the MDS coordinator signed and dated the assessment as complete on 11/1/21. During an interview on 11/2/21 at 3:05 PM the DON confirmed the assessment for the resident was late. She stated the facility was aware of late submissions of MDS assessments and were working to improve the process. 2. The following concerns regarding CAAs were identified: a. Review of section V0200 of the 6/3/21 annual MDS assessment for resident #17 showed pain triggered, which required a comprehensive assessment. Under "Location of CAA documentation" it read "current care plan continued current care plan continued new care plan started." Review of the care area trigger (CAT) worksheet for pain showed no analysis of findings. There lacked evidence of a comprehensive assessment for pain. b. Review of section V0200 of the 10/14/21 admission MDS assessment for resident #72 showed pain triggered, which required a comprehensive assessment. Under "Location of CAA documentation" for pain it read a new care plan was developed and mentioned the resident	F 636	identified this as an issue and has a QAPI created for it. - The delay in MDS's affects all of the neighbors in South Lincoln Nursing Center, we have created a QAPI plan to address and fix the issues so that all MDS's will be released on time. - Meeting held on 11/10/2021 with activities coordinator, dietary manager, RN who assists with MDS and the Administrator/DON regarding how to improve our timeliness of submissions. - New tracking sheet created to ensure that all MDS's are submitted no later then the last day on their sheet. The Administrator/DON will put the date and time per the CMS MDS page after each MDS is submitted to ensue they are released on time. This was created on 11/10/2021 and is updated with each MDS for the month. - Education provided to activities coordinator, dietary manager, RN who assists with MDS's on the tracking sheets on 11/11/2021. - New QAPI goal created to track that we will have 100% submission of all MDS's on time per the new tracking sheet. If we are late on any MDS, a meeting will be held to determine why we were late and how we will fix the issue. We will be 100% compliant by November 30, 2021, and be ongoing x 1 year. - Meeting held with RN who assists with MDS and education provided regarding the CAA documentation. It was determined that the CAA documentation will be done on the same worksheet explaining why the resident triggered a	

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F 636	Continued From page 3 received medications. Review of the care area trigger (CAT) worksheet for pain showed no analysis of findings. There lacked evidence of a comprehensive assessment for pain. c. During an interview on 11/4/21 at 8:43 AM the DON confirmed the residents did not have comprehensive assessments and they would work to improve the CAA process. 3. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual" (October 2019) by Centers for Medicare and Medicaid Services, showed for admission MDS assessments, "...The MDS completion date (item Z0500B) must be no later than day 14." In addition, "...Each triggered item must be assessed further through the use of the CAA process.....Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record...Use the "Location and Date of CAA Documentation" column on the CAA summary (section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record..."	F 636	CAA. After RN who assists with MDS's has done this, she will have the Administrator/DON review them to ensure accuracy. This was done on 11/10/2021. - All Annual CAA sheets will be printed out and kept in a binder for easy reference. This will be done by 11/30/2021 and be on going x 1 year.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than	F 637		11/30/21

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F 637	Continued From page 4 one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the Resident Assessment Instrument User's Manual, the facility failed to complete a significant change MDS assessment for 1 of 1 sample resident (#15) who required the assessment. The findings were: 1. Review of the electronic medical record for resident #15 showed a significant change MDS with an assessment reference date (ARD) of 9/24/21. Further review showed the assessment was listed as "open." 2. During an interview on 11/4/21 at 8:43 AM the DON stated the facility initiated a significant change MDS assessment in September 2021 after the resident broke a hip and his/her mobility changed. However, the DON stated the assessment was never transmitted. 3. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual" (October 2019) by Centers for Medicare and Medicaid Services, showed "...The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met..."	F 637	- Unable to go back and correct late submission of SCIC for resident #15. Upon further investigation, SCIC had been missed by the RN who assists with MDS's. - Late submission of all MDS's has the potential to affect all of the neighbors in South Lincoln Nursing Center and a QAPI plan has been created to fix the late submission of MDs's. - Meeting held on 11/10/2021 with activities coordinator, dietary manager, RN who assists with MDS and the Administrator/DON regarding how to improve our timeliness of submissions. - New tracking sheet created to ensure that all MDS's are submitted no later then the last day on their sheet. The Administrator/DON will put the date and time per the CMS MDS page after each MDS is submitted to ensue they are released on time. This was created on 11/10/2021 and is updated with each MDS for the month. - Education provided to activities coordinator, dietary manager, RN who helps with submission of MDS's regarding the tracking sheet was done on 11/11/2021. - New QAPI goal created to track that we will have 100% submission of all MDS's on time per the new tracking sheet. If we are late on any MDS, a meeting will be held to determine why we were late and	

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F 637	Continued From page 5	F 637	how we will fix the issue. We will be 100% compliant by November 30, 2021, and be ongoing x 1 year. - Meeting held with RN who assists with MDS and education provided regarding the CAA documentation. It was determined that the CAA documentation will be done on the same worksheet explaining why the resident triggered a CAA. After RN who assists with MDS's has done this, she will have the Administrator/DON review them to ensure accuracy. This was done on 11/10/2021. - All Annual CAA sheets will be printed out and kept in a binder for easy reference. This will be done by 11/30/2021 and be on going x 1 year.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		11/30/21

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F 656	Continued From page 6 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was comprehensive for 2 of 14 sample residents (#3, #16). The findings were: 1. Observation on 11/1/21 at 6:06 PM revealed resident #3 was outside smoking independently. Review of a 6/11/21 occupational therapy evaluation showed the resident was evaluated to determine ability to safely manipulate a cigarette and lighter in order to smoke. Review of the care plan, provided by the facility on 11/3/21, showed smoking was not addressed. 2. Review of the physician orders for resident #16	F 656	- Resident #3 care plan was corrected to reflect that she is a smoker on 11/4/2021, and the other two residents that live in SLNC were also updated at this time to reflect that they are smokers. - Resident #16 care plan was corrected to reflect the antipsychotic, antidepressant and anticoagulation drugs on 11/4/2021. - Comprehensive care plans affect all of the neighbors cares and this has been identified as major issue. QAPI plan has been created to fix this issue for all neighbors. - Education was provided to activities coordinator, dietary manager, RN who	

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F 656	Continued From page 7 showed medications included quetiapine (antipsychotic), Zoloft (antidepressant), and Warfarin (anticoagulant). Review of the care plan, provided by the facility on 11/3/21, showed the medications were not addressed. 3. During an interview on 11/4/21 at 8:43 AM the DON confirmed smoking was not addressed on the care plan for resident #3. In addition, she stated the psychotropic medications and anticoagulant medication were not addressed for resident #16, but should have been. She further stated the facility had identified issues with care plans and was currently working to improve them.	F 656	assists with MDS's regarding the new QAPI plan and printing out care plans prior to care conferences and reviewing care plan during care conference with changes made right then. This was done on 11/11/2021. - All residents care plans will be 100% updated to reflect medications, lab draws, and individual needs by November 20,2021. - New QAPI created to ensure that all care plans will be reviewed on a quarterly basis for each resident. The care plans will be printed off prior to the care conference and reviewed during the care conference with changes being made at that time. We will be 100% by November 30,2021 and be onging x 1 year.	
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.	F 868		11/17/21

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F 868	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on review of facility quality assessment and assurance (QAA) documentation and staff interview, the facility failed to ensure the QAA committee included the DON and the administrator, owner, board member or other individual in a leadership role. The census was 23. The findings were: 1. Interview on 11/3/21 at 8:32 AM with the quality assessment and process improvement (QAPI) committee chair revealed neither the DON nor administrator part of the committee. 2. During an interview on 11/3/21 at 8:43 AM the DON, who was also the administrator, confirmed she was not part of the committee. 3. Review of the facility's "South Lincoln Hospital District Committee Charter: Quality Assurance Process Improvement (QAPI) Committee," updated 5/22/21, showed the committee membership did not include the DON or administrator (or other individual in leadership role).	F 868	1. Email sent to the CEO and COO of South Lincoln Hospital District with Dr. Weston cc'd on 11/4/2021 updating them on the federal regulations regarding the Administrator/DON being on the QAPI committee. The CEO agreed with moving forward to place the Administrator/DON back on the QAPI committee. 2. The QAPI committee chair notified that the Administrator/DON of long term care needs to be added to the committee to follow federal regulations. 3. On 11/10/2021 IT notified via email to add the long term care Administrator/DON to the QAPI committee email. 4. New QAPI goals submitted to the QAPI committee chair, that the administrator/DON of long term care will attend 100% of the QAPI committee meetings by the end of November and this will be an ongoing goal for the next year. 5. Administrator/DON attended the first QAPI committee meeting on November 17, 2021 @ 2pm.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a	F 881		11/30/21

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F 881	Continued From page 9 system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to apply systemic practices to monitor the use of antibiotics for 1 of 2 (#6) sampled residents reviewed for antibiotics. The findings were: 1. Review of the 10/12/21 quarterly MDS assessment showed resident #6 was admitted to the facility on 8/8/19 with diagnoses that included diabetes mellitus, flaccid neuropathic bladder, neuromuscular dysfunction of bladder, urinary tract infection (UTI), benign prostatic hyperplasia with lower urinary tract, retention of urine, and presence of urogenital implants. Further review showed the resident had an indwelling catheter. The following concerns were identified: a. Review of physician orders showed an order for "Gentamicin [an antibiotic] 80mg/2mL vial flush Foley catheter with 60mL, clamp catheter for 10 minutes then unclamp" related to retention of urine, and written on 1/4/21 with no end date. b. Review of the documents entitled "Consultant Pharmacist Medication Regimen Review (MRR) and Physician Notification" for the previous four months showed no documentation related to antibiotics from the physician or pharmacist, with the exception of a pharmacist note dated 9/7/21 stating "Reviewing alternatives to gent [sic] flush." c. Review of the medical record showed no documented justification for the continued use of the Gentamicin antibiotic flushes with no end date. d. Interview with the DON on 11/4/21 at 9:22 AM revealed the resident was on the Gentamicin	F 881	- Urologist in Rock Springs Wyoming faxed records over for resident #6. These records were faxed to the State Survey and scanned to the primary care physician for review. Upon further review by the primary care physician of these notes, the gentamicin flush was discontinued on 11/17/201 and resident #6 was started on oral Cefdinir 300mg po BID x 30 days on 11/17/2021. - Administrator/DON will go back to typing up an email to the primary care physician and their MA regarding why a resident was 1) started on an antibiotic including symptoms and dx if discussed with primary care physician 2) dose and duration of the antibiotic 3)and any other pertinent information regarding residents symptoms prior to antibiotic use. This was re-started on 11/4/2021 and will be ongoing for all antibiotic usage. - MTM form that the facility is currently using was changed to include antibiotic use both within the month and a prophylactic's use. This will ensure that any antibiotic used within the moth will be reviewed by the consulting pharmacist, DON, and Primary Physician. This was done on 11/4/2021 and approved by the consulting pharmacist, DON, and Nursing Home Medical Director. The form will be used for the MTM's for the month of November. - Education provided to consulting pharmacist and medical director regarding documentation needs related to changes	

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F 881	Continued From page 10 antibiotic flushes prophylactically, and the resident did not currently have a UTI. She also confirmed neither the MRR nor the resident's medical record contained documented justification addressing the antibiotic flushes. e. Review of facility policy "Clinical Protocol/Procedure Antibiotic Stewardship", last reviewed 10/17/2020, showed "If a resident is on a prophylactic antibiotic regime then the primary care provider will document every month the reason for the prophylactic antibiotic regime." Review of facility policy "Clinical Protocol/Procedure Tracking Infections", last reviewed 1/18/21, showed "An antibiotic will not be started for a UTI until the urine culture is back in an attempt to prevent bacteria resistance unless specified by the provider due to the resident's symptoms." Review of the facility policy "Clinical Protocol/Procedure Antibiotic Record Keeping", last reviewed 10/19/21, showed "Every antibiotic prescription must be documented in the electronic health record including the dose, duration and indication for the antibiotic." Further review showed if an antibiotic is used prophylactically, then the " ...prescribing physician will place a note in the electronic health record explaining why the neighbor is being treated with prophylactic antibiotics."	F 881	on the form and documentation needs for antibiotic stewardship. This was done on 11/11/2021. - On the public drive, there is a locked IDT folder that the Nursing Home Medical Director and Consulting Pharmacist were added to the IDT folder. This was done on 11/15/2021. - In the IDT folder a separate folder was made labeled MTM folder and within that folder the signed MTM's will be scanned in after the consulting pharmacist, DON, and primary care physician has signed them. This will allow continued communication with the consulting pharmacist regarding why the physicians agree or disagree with the recommendations. This was done on 11/4/2021. - New QAPI goal submitted regarding ensuring proper documentation for each antibiotic use on all residents within South Lincoln Nursing Center. this will be done by November 30, 2021 and be ongoing x 1 year.	