STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/27/22 to 3/2/22. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted on 2/27/22 to 3/2/22. Based upon the findings of the survey team, it was determined that no deficiencies were indentified pertaining to the Omnibus COVID-19 Health Care Staff Vaccination requirements. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect,	F 606		4/8/22

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

Electronically Signed | 03/23/2022

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 606	Continued From page 1 exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure CNA abuse registry checks were performed for 2 of 3 sample CNAs (#1, #2) prior to resident contact. The findings were: 1. Review of the employee file for CNA #1 showed the CNA had an active Wyoming CNA certification with an expiration of 12/31/22. Further review showed there was no evidence an abuse registry check was performed. 2. Review of the employee file for CNA #2 showed the CNA had an active Wyoming CNA certification with an expiration of 12/31/22. Further review showed there was no evidence an abuse registry check was performed. 3. Review of the Wyoming Abuse registry on 3/2/22 at 1:20 PM showed CNA #1 was not listed on the registry. 4. Interview with HR #1 on 3/2/22 at 1:21 PM revealed the facility did not verify CNAs did not	F 606	The facility will ensure that newly hired CNAs are checked against the abuse registry prior to resident contact. This will be accomplished by: 1) HR updating the New Hire Checklist. Elements have been added to ensure that the abuse registry check was completed and documented in the new employee's file. 2) An audit, to be completed by the DON or designee, using an audit tool will be performed within 24 hours after each new hire has signed their official job offer from CCMSD. 3) 100% of the current CNAs will be checked against the abuse registry and the registry will be updated if necessary. 4) The DON will educate HR on the new process/forms. 5) The audit results will be presented to QAPI to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F606.	

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F 606	Continued From page 2 have findings of abuse, neglect, or exploitation on the Wyoming abuse registry prior to resident contact.	F 606		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of nurse schedules, review of posted staffing, and staff interview, the facility failed to ensure the services of an RN were used for at least 8 consecutive hours a day, 7 days a week. The census was 24. The findings were: 1. Review of the nurse schedule from 11/7/21 through 3/1/22 showed there was not 8 consecutive hours of RN staffing scheduled on 6 days: 12/3/21, 12/4/21, 12/5/21, 12/18/21, 12/19/21, and 2/5/22. 2. Review of the posted nurse staffing from 11/1/21 through 3/1/22 confirmed no RN worked 8 consecutive hours on 12/3/21, 12/4/21, 12/5/21, 12/18/21, 12/19/21, and 2/5/22.	F 727	The facility will ensure that there is RN coverage 8 consecutive hours a day, 7 days a week. This will be accomplished by: 1) Scheduling a RN for at least 8 hours a day, 7 days a week; this may include the infection control RN, PRN RN, or DON. 2) The posted nurse staffing sheet will reflect that there is coverage 8 consecutive hours a day, 7 days a week. 4) The CEO will ensure that there is a RN for 8 consecutive hours, 7 days a week. The nursing staff will be educated on the regulation. 5) This facility will continue to offer a sign-on bonus, employee referral	4/15/22

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F 727	Continued From page 3 3. Interview with the DON on 3/1/22 at 5:30 PM revealed the facility did not always have RN coverage for 8 consecutive hours due to a lack of RNs employed by the facility. In addition, she revealed they had difficulty recruiting staff to the facility.	F 727	incentive, and competitive hourly wages for registered nurses in an ongoing attempt to attract and hire additional registered nurses. DON and HR will be attending a virtual job fair on 3/23/2022 in an effort to hire registered nurses.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		4/8/22

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F 758	Continued From page 4 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. 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 appropriate diagnoses and target symptoms were identified for 4 of 5 sample residents (#2, #5, #21, #22) reviewed for unnecessary psychotropic medications. The findings were: 1. Review of the quarterly MDS assessment dated 11/25/21 showed resident #2 had diagnoses which included depression and had a BIMS score of 7 out of 15, which indicated severe cognitive impairment. Further review showed the resident PHQ-9 score of 0, which indicated minimal depression. Review of the physician orders provided by the facility on 3/1/22 showed the resident received venlafaxine hydrochloride (anti-depressant) extended release 75 mg (milligrams) by mouth daily at bedtime for major	F 758	The facility will ensure that residents are free from unnecessary psychotropic medication use and identify appropriate diagnoses and target symptoms and monitor the drug use appropriately. This will be accomplished by: 1) IDT will review the care plans for residents #2,5,21,22 and identify target symptoms for the use of the psychotropic medications. A task will be added to the TAR every shift for the nurse to monitor the identified target symptoms for each resident. 2) Review of all the resident's medication lists will be reviewed by the IDT committee and target symptoms will be identified when necessary. Diagnosis related to the use of psychotropic medications will also be reviewed to	

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F 758	Continued From page 5 depressive disorder. The following concerns were identified: a. Review of the antidepressant care plan last reviewed 2/25/22 showed no identified target symptoms for use of the medication. b. Review of the medication administration record for December 2021, January 2022, and February 2022 showed no identification or monitoring of target symptoms for the anti-depressant medication. 2. Review of the quarterly MDS assessment dated 12/29/21 showed resident #5 had diagnoses which included unspecified dementia without behavioral disturbance, and no behavior symptoms were coded. Further review showed the resident had a BIMS score of 99, which indicated the resident was unable to complete the interview. Daily behavioral symptoms directed and not directed toward others were coded. No depression symptoms were present. Review of the medication orders showed the resident received seroquel (antipsychotic) 6.25 mg by mouth every day at bedtime, buspirone (anti-anxiety) 10 mg by mouth, and sertraline (antidepressant) 50 mg by mouth daily. Review of the care plan titled, "I use psychotropic medications-Seroquel r/t [related to] Behavior management" last revised on 1/18/22 showed interventions which included "Monitor/document for side effects and effectiveness...report to MD prn side effects and adverse reactions...Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS, frequent falls, refusal to eat..." Review of the care plan titled, "I use antidepressant medication Sertraline and an antianxiety medication Buspar r/t anxiety" last revised on	F 758	ensure they are appropriate for the use of the medication. - Upon review, this facility will attempt gradual dose reductions on any residents who are identified as using long-standing psychotropic medications with no GDR charted. 3) Care plans will be individualized and target symptoms will be identified and monitored. 4) The admission checklist has been updated to include identification/monitoring of psychotropic medications and their target symptoms starting upon admission. 5) A form called "Resident Psychotropic Medication Use" has been created and will be added to the admission packet for office staff. The form monitors nonpharmacological approaches used, target symptoms, care plan updates, consents signed by resident and/or POA for psychotropic use, date of 1st GDR (gradual dose reduction) and 2nd GDR within the first year. The second page of the form monitors yearly GDR unless clinically contraindicated. 7) The facility created an in-depth policy directed at psychotropic medication use and gradual dose reduction. The DON or designee will educate nursing staff on the new process. 8) An audit, completed by the DON or designee, using an audit tool will be done on 100% of the residents to ensure the review of psychotropic medications, target symptoms, and appropriate diagnosis have been reviewed. This audit will be reviewed by the IDT committee weekly to	

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F 758	Continued From page 6 1/13/22 showed interventions which included "monitor/document side effects and effectiveness...Report to Nurse s/sx of following: confusion, mood change, change in normal behavior..." The following concerns were identified: a. Review of the medication administration record for December 2021, January 2022, and February 2022 showed no identification or monitoring of target symptoms for the antipsychotic, anti-anxiety, and anti-depressant medications. 3. Review of the quarterly MDS assessment dated 1/4/22 showed resident #21 had diagnoses which included depression and had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed the resident PHQ-9 score of 0, which indicated minimal depression. Review of the physician orders provided by the facility on 3/1/22 showed the resident received venlafaxine hydrochloride extended release 37.5 mg by mouth daily for major depressive disorder. Review of the antidepressant care plan last reviewed 1/18/22 showed interventions which included "Monitor/document/report to MD prn [as needed] ongoing s/sx [signs and symptoms] of depression unaltered by antidepressant meds Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. [negative] mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance..." The following concerns were identified:	F 758	ensure each element is completed. 9) An audit, completed by the DON or designee using an audit tool, will be done on each new admission within 48 hours of admission to ensure that psychotropic medication(s) have been identified along with target symptoms and proper diagnosis. 10) The results of these audits will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F758.	

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F 758	Continued From page 7	F 758		

a. Review of the medication administration record for December 2021, January 2022, and February 2022 showed no identification or monitoring of target symptoms for the anti-depressant medication.

4. Review of the quarterly MDS assessment dated 11/17/21 showed resident #22 had diagnoses which included unspecified intellectual disabilities, unspecified psychosis not due to a substance or known psychological condition, major depressive disorder, single episode, unspecified, and had a BIMS score of 6 out of 15, which indicated the resident was severely cognitively impaired. PHQ-9 assessment showed "feelings of down, depressed" with a frequency of several days. No behavioral symptoms were coded. Review of the physician orders showed the resident received seroquel (antipsychotic) 100 mg by mouth daily at bedtime and trazodone (antidepressant) 100 mg by mouth at bedtime. Review of the care plan titled, "I use psychotropic medications-Quetiapine r/t intellectual disability" last revised on 9/16/21 showed interventions which included, "Monitor/document for side effects and effectiveness...report to MD prn side effects and adverse reactions...Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medication: unsteady gait, tardive dyskinesia, EPS, frequent falls, refusal to eat..." Review of the care plan titled, "I use antidepressant medication trazodone r/t Depression and insomnia" last revised 9/16/21 showed interventions which included, "Monitor/document side effects and effectiveness...Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never

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F 758	Continued From page 8 satisfied, crying..." The following concerns were identified: a. Review of the medication administration record for December 2021, January 2022, and February 2022 showed no identification or monitoring of target symptoms for the antipsychotic and anti-depressant medication. 5. Interview with RN #1 on 2/22/22 at 9:28 AM confirmed the facility did not have a process to monitor and document target symptoms. 6. Interview with the DON on 3/1/22 at 5:20 PM revealed the facility did not have a process for identifying target symptoms or routine monitoring of target symptoms to determine the effectiveness of medication. Further interview revealed the facility was aware that some diagnoses provided for the use of psychotropic medications were not appropriate for the use of the medications. 7. Interview with the DON on 3/2/22 at 11:08 AM revealed the facility did not have a policy and procedure related to the use of psychotropic medication use.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		3/24/22

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F 880	Continued From page 9	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 10 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure visitors were screened for COVID-19 prior to entering the facility. The census was 24. The findings were: On 2/27/22 at 2:16 PM, the survey team consisting of 3 surveyors entered the common area at the front of the facility shared by the nursing home and critical access hospital. Signage was located just inside the door stating staff would screen those who entered for COVID-19 , and listing signs and symptoms that an individual should refrain from entering if any were experienced. The following concerns were identified: a. Observation on 2/27/22 at 2:16 PM showed the 3 surveyors on the team were not screened by staff for COVID-19 upon entrance to the facility area shared by the adjacent critical access hospital. No staff were observed to be	F 880	This facility will ensure that visitors are screened for COVID-19 prior to entering the facility. This will be accomplished by: 1) Placing signage in the lobby directing visitors to self screen using the iPad/screening log that is provided by the facility. Signage will be bright and attention grabbing to ensure visitors have stopped to self-screen before entering the facility. To ensure visitors are self-screening, the nurses will continue to fill out the LTC visitor log. The DON or IP will compare the self-screening log/iPad daily against the LTC visitor log to ensure compliance. 2) The facility has also placed a phone in the lobby for visitors to use and call long-term care if they need assistance with being screened. Signage will also be bright and attention grabbing so visitors are aware of our process for	

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CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 present in that area, and there was no impediment to entrance. In addition, the survey team members were not screened at that time upon entrance to the nursing home area. A set-up for screening was located across from the nursing desk, which was in the middle of the facility. Staff were present, and no staff member offered to screen the 3 surveyors. On 3/1/22 at 8 AM, the surveyors entered the facility and again were not screened for COVID-19. b. Interview with the infection preventionist on 3/2/22 at 9:24 AM confirmed staff were required to screen all individuals who entered the facility for COVID-19. She stated the business office staff, during open business hours, were required to screen individuals who entered the facility. Her expectation during after hours was for facility staff to screen those who enter. She confirmed the screening process should take place before entering the facility, and setting up the screening process in the middle of the facility was not acceptable. She further confirmed the facility failed to formulate a policy to address screening of individuals who enter the facility, for COVID-19. Interview with business office staff member #1 on 3/2/22 at 9:39 AM revealed the business office hours were 8 AM to 4 PM, Monday through Friday. c. Review of the facility policies showed there were policies that addressed standard precautions, the COVID-19 vaccination requirements, influenza vaccination, and antibiotic stewardship. The review showed none of these policies addressed screening of visitors and staff for COVID-19 when entering the facility.	F 880	after-business hours (4p-8a). 3) This facility has created a policy addressing the process of screening visitors and staff for COVID-19 when entering the facility. 4) Log will be created to ensure business office staff have placed the self-screening station in the lobby for after-hour visitors. An audit, by the DON or designee, using an audit tool will be used weekly to ensure compliance. 5) The DON or IP nurse will educate business office personnel and nursing staff on the new process. 6) Audit results will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F880	