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	535025	A. BUILDING _____ B. WING _____	C 04/08/2022

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 4/7/22 through 4/8/22. The survey was prompted by complaint intakes WY00003368, WY00003382, WY00003383, WY00003385, WY00003390. In addition a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. The following common abbreviations are used throughout the document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nursing Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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 -	F 656		5/23/22

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

Electronically Signed | 05/02/2022

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F 656	Continued From page 1 (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 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 comprehensive care plan was updated and revised when resident care needs changed for 1 of 3 sample residents (#6). The finding were: 1. Review of the 2/28/22 admission MDS assessment showed resident #6 had diagnoses	F 656	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	

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F 656	Continued From page 2 which included hypertension (HTN), type 2 diabetes mellitus (DM II),localized edema, history of venous thrombosis and embolism, history of pulmonary embolism, and lymphedema. Further, the skin treatment section included application of nonsurgical dressing. Review of the progress note dated 4/6/2022 at 5 AM showed "Administration Note: Cleanse [bilateral lower extremities] BLE with wound wash-pat dry-apply urea cream 5% to BLE from toes to knees-apply Ace wraps to BLE utilizing figure 8 method; toe to knee. Apply in AM. Off at HS [bed time]. one time a day for Edema and remove per schedule..." Resident has a shower today and wants [his/her] legs wrapped after [his/her] shower." The following concerns were identified: a. Observation on 4/7/22 at 4:55 PM and on 4/8/22 at 10:45 AM showed the resident sitting in a wheelchair wearing TED hose (compression stockings) on his/her lower legs. b. Review of the April 2022 physician orders showed "Ace wraps to bilateral [lower extremities] LE utilizing figure 8 method; toe to knee. Apply in AM. Off at [bed time] HS. one time a day for Edema and remove per schedule." In addition, the order for the Ace wrap to BLE was removed on 4/8/22. Further review showed a new order dated 4/8/22 with start date on 4/9/22 of "{Apply} knee high TED hose to BLE every AM remove at HS. one time a day for lymphoedema and remove per schedule." c. Review of the care plan hand delivered by the DON on 4/8/22 showed "Cardiovascular/Circulatory: [resident name] has altered cardiovascular status [related to] r/t factor 5 disorder, DMII and HTN, revision on 1/26/22... Observe/document any edema. Note extent and report to MD." Further review showed the care plan failed to include the wrapping of the lower	F 656	of correction serves as the facilities allegation of compliance. F656 Care Plans Correction: Resident #6□s care plan was updated on 5-2-22 by the RCMD to include the placement of the TED hose. Identification: The MDS Coordinator will complete an audit of current residents who are receiving treatments to ensure care plans are in place for each resident. This will be completed by 5-23-22. Systemic: In-service education will be provided to the MDS Coordinators prior to 5-23-22 by the DON/Designee regarding the need to ensure accurate and timely care plans are in place for all residents who receive treatments. The MDS Coordinator will audit 2 residents per week to ensure accurate care planning is completed for all residents who are receiving treatments. Monitoring: The MDS Coordinator reports any identified patterns or trends from the observations of the care plans to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These observations will continue for 3 months unless the QAPI Committee deems it prudent to continue.	

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F 656	Continued From page 3 extremities, and time of placement or removal of the wraps. In addition the care plan failed to address the placement of the TED hose. d. Interview with the DON on 4/8/22 at 2 PM revealed it was the facility's expectation for the staff to follow the physician's orders and care plan.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, and medical record review the facility failed to ensure the resident received care in accordance with a person-centered care plan for 1 of 9 resident sample (#3). The finding were: 1. Review of the 2/10/22 quarterly MDS assessment showed resident #3 had a BIMS score of 12 out of 15 (mildly impaired for cognition). The assessment showed the resident required supervision with limited assistance for locomotion and eating. The diagnoses included medically complex conditions, bilateral nuclear cataract, non-Alzheimer's dementia, dementia with Lewy bodies, repeated falls, abnormalities of gait and mobility, muscle weakness, transient ischemic attack,cerebral infarction,and lack of	F 684	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 facilities allegation of compliance. F684 Quality of Care Correction: Resident #3 is receiving water/preferred fluids with and between meals. Staff is ensuring she is receiving fresh water once per shift and as requested.	5/23/22

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F 684	Continued From page 4 coordination. Review of the nutrition care plan included "Encourage water and other preferred fluids with and between meals. Monitor for signs and symptoms of dehydration. " The following concerns were identified: a. Observation on 4/8/22 at 9 AM of the residents room showed there were no beverage cups in the area. b. Interview on 4/8/22 at 10:45 AM with a family member revealed the resident had been diagnosed with dehydration in January. The family member visited every day and had to ask for water for the resident frequently. Interview on 4/8/22 at 11:20 AM with CNA #2 verified water was passed to the residents once a shift. She reported providing water to the resident at 10 AM the day, but only after the resident's family member requested some. Further, the CNA confirmed there was not a cup in the resident's room prior to that. c. Interview on 4/8/22 at 3:30 PM with the DON revealed the facility was in the process of buying new drinking cups for the residents. However, it was the facility's expectation for water to be passed three times a day, and as requested.	F 684	Identification: All other residents have the potential to be affected by this alleged deficient practice. Systemic: In-service education will be provided to staff prior to 5-23-22 by the DON/Designee regarding encouraging fluids with and between meals and passing of water every shift. The DON/Designee will complete random audits 3x/wk x 4 week, then 2x/wk x 4 weeks, then weekly x 4 weeks to ensure that residents are receiving fluids per facility protocol. Monitoring: The DON/Designee reports any identified patterns or trends from the observations of the fluid monitoring to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These observations will continue for 3 months unless the QAPI Committee deems it prudent to continue.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 726		5/23/22

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F 726	Continued From page 5 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staffing agency contract review, staff interview, medical record review, facility training documentation review, and employee record review, the facility failed to ensure nursing staff had the required competencies and skill sets for their assigned duties for 1 of 5 nursing staff (LPN #1) reviewed . The findings were: Review of a nursing note for resident #10 dated 8/10/20 and timed at 5:14 PM showed LPN #1 electronically signed the note. The following concerns were identified: a. Further review of the nursing note for resident #10 dated 8/10/20 and timed at 5:14 PM showed LPN #1 was represented as an RN. b. Review of the 7/1/21 contract between a	F 726	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 facilities allegation of compliance. F726 Competent Staffing Correction: LPN #1 no longer works at the facility. Identification of Others: HR Director will audit all RN, LPN and CNA files to verify	

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F 726	Continued From page 6 staffing agency and a former facility administrator showed LPN #1 was contracted to work at the facility as an LPN. c. Review of the employee record for LPN #1 showed a license verification for an RN who had the same name as LPN #1. d. Review of a 12/10/21 "In-Service Report" showed LPN #1 was the instructor for the training, and physically signed the documentation and represented him/herself as an RN. e. The survey team attempted to interview LPN #1, however, phone calls were not returned. f. Interview on 4/7/22 at 3:30 PM with the facility administrator and DON revealed each had believed LPN #1 to be an RN while s/he was employed at the facility, and the LPN was working as an RN and unit manager when the facility administrator and DON came to work at the facility. Neither had suspected the LPN was not qualified for his/her position until they were contacted by an outside party with concerns. The administrator and DON suspected a former employee inadvertently verified the wrong license (an RN with the same name as LPN #1) when LPN #1 began work at the facility, and LPN #1 did not correct the error. They further stated LPN #1 unexpectedly ended his/her employment at the facility on 12/21/21 without notice.	F 726	licenses are correct prior to 5-23-22. Systemic: In-servce education will be provided to the HR Director by the NHA/Designee prior to 5-23-22 regarding verification of licenses. 10% of employee files will be audited monthly by the NHA/Designee to ensure licenses are accurate and current. Monitoring: The NHA/Designee reports any identified patterns or trends from the audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These observations will continue for 3 months unless the QAPI Committee deems it prudent to continue.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		5/23/22

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F 761	Continued From page 7 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility policy the facility failed to ensure medication storage was secure and safe for 1 of 2 (North medication storage room) medication storage rooms. The findings were: 1. Observation on 4/7/22 at 4 PM showed the north medication room door was held open by a clear plastic trash bag which was looped at the ends and secured to a metal shelf on the inside of the room and to the door knob. Further observation showed a large cardboard box filled to overflowing with cards of medication sitting on the counter. The following concerns were identified: a. Inside the room was an employee who identified herself as from "central supplies". The employee stated she was unsure where the nurse was at that time. Further observation at that time	F 761	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 facilities allegation of compliance. F761 Label/Store Drugs and Biologicals Correction: Signs were placed on the medication storage rooms instructing nurses that propping the door open is not allowed and that non-licensed staff can not be in medication room unsupervised. Identification: Medication rooms were inspected to ensure that automatic	

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F 761	Continued From page 8 showed multiple staff and residents in the area of the unsecured medication room. b. Interview on 4/8/22 at 11 AM with RN #2 revealed only the nurse on duty had the keys to the medication storage and the assigned medication carts. Observation at that time showed the RN used the clear plastic trash bag looped at the ends to secure the door open. She stated she secured the door open because she was claustrophobic. c. Interview on 4/8/22 with the DON at 4 PM revealed only the nurses on duty have the keys to the medication storage rooms. 2. Review of policy "Storage of Medications" revised November 2020 showed "1. ...Only persons authorized to prepare and administer medications have access to locked medications."	F 761	closures were in place. Systemic Change: In-service education will be provided to licensed staff prior to 5-23-22 by the DON/Designee regarding the Storage of Drugs and Biologicals. DON/Designee will complete random audits 3/wk x 8 weeks and 2/wk x 4 weeks to ensure compliance. Monitoring: Monitoring: The DON/Designee reports any identified patterns or trends from the observations of Storage of Drugs and Biologicals to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. These observations will continue for 3 months unless the QAPI Committee deems it prudent to continue.	