STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	**1210 CANYON HILLS RD THERMOPOLIS, WY 82443**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/28/22 to 3/31/22. Also reviewed in the course of the survey was complaint intake WY00003378. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted on 3/28/22 to 3/31/22. Based upon the findings of the survey team, it was determined that no deficiencies were identified pertaining to the Omnibus COVID-19 Health Care Staff Vaccination requirements. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DNS- Director of Nursing Services MAR-Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		5/14/22

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

Electronically Signed | 05/03/2022

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F 584	Continued From page 1 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a clean environment in 1 of 2 dining areas (main dining). The findings were: Observation of the main dining area and adjacent hallway on 3/30/22 at 9:15 AM showed the	F 584	1. The facility will maintain a safe, clean, comfortable, and homelike environment including that surfaces be sanitzable. The facility is having the entire dining floor area replaced (including hall entryway) before date of compliance. The cabinets and countertops cited (and found during	

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F 584	Continued From page 2 following concerns: a. Multiple pockmarked areas on the floor were noted which created an uncleanable surface, and the areas were blackened and had collected dirt and debris. b. The floor on the short hallway from the main dining area to the main hallway had the following 4 damaged areas that were blackened with dirt and debris due to an uncleanable surface: an 8 inch by 4 inch gash, a 6 inch by 1 inch gash, a 4 inch by 1/2 inch gash, and a 3 inch by 1 inch gash. c. A cabinet door by the serving window had approximately 50% of the paint chipped off which measured 13 inches by 24 inches, and created an uncleanable surface. In addition, the counter area above and to the left of the damaged cabinet door had a 3 inch by 1 inch area chipped out, which created an uncleanable surface. d. To the right of the sink on the counter above the cabinets was a 20 inch area with the border stripped off, and the corner completely chipped off. Red tape was applied and was coming loose, appeared dark and dirty with collected debris, and was an uncleanable surface. Interview in the main dining area with the maintenance director on 3/30/22 at 10:51 AM confirmed he was aware of the issues with the damaged floor, cabinet door, countertop, and area surrounding the sink. He stated the facility had attempted to get bids for repairs to that area, and in the kitchen. However, he revealed the facility failed to have a written plan with a timeframe to start and complete those repairs.	F 584	initial audit) are being stripped, repaired, and painted as needed in order to be fully sanitizable. All kitchen floor tile cited (and found during initial audit) are being replaced. The facility has obtained a bid from a contractor to replace all cabinetry, countertops, wall covering and kitchen flooring within the next 3 months. 2. Audit completed by Executive Director/designee on 04/01/2022 of resident care areas to identify items which may need repair or replacement. Identified areas of concern will be added to maintenance schedule log as appropriate. 3. Executive Director will educate all Maintenance and Housekeeping staff on the requirement that all surfaces in the kitchen and main dining area are to be sanitizable and in good repair. Executive Director/Designee will audit weekly times three months to identify, schedule, and correct areas of concern. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly x 3 months (90 days) for further recommendations.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		5/14/22

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F 656	Continued From page 3	F 656		

§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 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

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F 656	Continued From page 4 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 resident interview, medical record review, and staff interview, the facility failed to ensure an individualized comprehensive care plan was completed for 2 of 13 sample residents (#29, #30). The findings were: 1. Review of the 2/23/22 admission MDS assessment for resident #29 showed the resident was admitted to the facility on 2/17/22 following joint replacement surgery. The resident had a BIMS score of 13/15 (cognitively intact), had a stage 2 pressure ulcer on his/her left heel, and had frequent pain at a moderate level in which s/he received as needed pain medication and non-medical interventions. Review of a physician order showed 100 milligrams of gabapentin 3 times daily for aftercare following joint replacement surgery and 300 milligrams of gabapentin one time a day for left lower extremity pain had been ordered on 3/15/22. Interview with the resident on 3/30/22 at 2:02 PM revealed when s/he was walking his/her feet were in constant pain. The resident stated s/he was supposed to keep his/her feet elevated, however did not always comply. In addition, the resident stated the facility had him/her keep a pain journal to pinpoint what triggered the pain. The following concerns were identified: a. Review of the pain care plan showed the resident's goals were revised on 3/3/22 and included: "The resident will display a decrease in behaviors of inadequate pain control (SPECIFY: irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying:	F 656	1. Resident #30's care plan was updated to address pain interventions. Resident #29's care plan was updated to include monitoring for target behaviors as well as provision of alternate activities to help mitigate behaviors. 2. Audit completed by DNS/Designee on 04/01/22 to identify other individualized care plan concerns. 3. DNS/Designee will educate nursing staff on the requirement and significance of individualized care plans as well as how to recognize physical/behavioral indicators. DNS/Designee will provide ongoing audits weekly times three months reviewing 5 to 10 random care plans per week for individualized care plan concerns. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly x 3 months (90 days) for further recommendations.	

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F 656	Continued From page 5	F 656		

through the review date." The care plan interventions/tasks, last revised 2/21/22, included "The resident's pain is aggravated by: (SPECIFY): and "Evaluate the effectiveness of pain interventions (SPECIFY FREQ):.."

b. Review of the pressure ulcer care plan initiated on 2/21/22 showed the interventions/tasks included: "Monitor dressing (SPECIFY FREQ) to ensure it is intact and adhering. Report lose (sic) dressing to Treatment Nurse" and "The resident requires (SPECIFY: Pressure relieving/reducing device) on (SPECIFY: bed/chair)".

c. Interview on 3/31/22 at 9:21 AM with the MDS coordinator confirmed the care plan was incomplete.

2. Review of the 11/7/21 admission MDS assessment showed resident #30 was admitted to the facility on 11/1/21. The resident was coded as being severely cognitively impaired, exhibited behaviors not directed towards others on a daily basis, and received an antipsychotic 5 days of the 7-day look-back period. The resident received 25 milligrams of Seroquel 2 times daily and was monitored for behaviors which included: anger, combativeness, restlessness, yelling out, refusal of care, and cussing. The following concerns were identified:

a. Review of the resident's behavior care plan initiated on 11/9/21 showed no evidence the facility had developed a plan which included targeted behaviors and interventions related to the use of antipsychotic medication.

b. Interview on 3/31/22 at 9:21 AM with the MDS coordinator revealed the facility was currently without a social worker who was responsible for completing the behavior portion of the care plans. The MDS coordinator confirmed

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F 656	Continued From page 6 the care plan was incomplete.	F 656		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		5/14/22

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F 732	Continued From page 7 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the posted nurse staffing data and staff interview, the facility failed to ensure the posted 24/7 hour nursing staff included all required information. The census was 38. The findings were: 1. Review of the 3/1/22 through 3/28/22 daily nurse staffing information showed the following concerns: a. Review of 6 out of 28 (3/5, 3/6, 3/19, 3/20, 3/26, 3/27) daily nurse staffing information posts failed to include the number of hours the RN was on duty. b. Review of 24 out of 28 daily nurse staffing information posts failed to include the resident census. 2. Interview with the DNS on 3/29/22 at 4:42 PM confirmed the nurse staffing data information posts were incorrect.	F 732	1. The daily nurse staffing report is accurate, complete including daily census, and posted daily where it is plainly visible. 2. Executive Director/designee will complete an initial audit on 04/01/22 three times per week for one week to assess for a complete and accurate staff posting. 3. Executive Director will provide education to the DNS on the requirement that the daily nurse staffing report be accurate and complete including census, RN hours, and posted daily where it is plainly visible. Executive Director will complete ongoing audits twice weekly to assess for a complete and accurate staff posting weekly times three months. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly x 3 months (90 days) for further recommendations.	
F 758 SS=D	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	F 758		5/14/22

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F 758	Continued From page 8 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 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, power of attorney (POA) interview, and staff interview, the	F 758	1. Resident #19 has expired. 2. Audit completed DNS/Designee on	

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F 758	Continued From page 9 facility failed to ensure the medication regimen was free from unnecessary medications for 1 of 5 (#19) sample residents reviewed for medications administered for behaviors. The findings were: Review of the 2/1/22 quarterly MDS assessment showed resident #19 was admitted to the facility on 10/27/21 with diagnoses which included morbid obesity, diabetes mellitus II, and dementia with behavioral disturbance. The review showed the resident had a brief interview for mental status score of 8, indicating moderate cognitive impairment. The following issues were identified: a. Review of the physician orders showed the resident had a 1/25/22 order for Seroquel (antipsychotic) 25 milligrams by mouth daily for dementia with behavioral disturbance. The review showed specific targeted behaviors were not documented. b. Review of the medication administration record for January, February, and March showed the resident received the Seroquel as ordered. The review showed no specific targeted behaviors as being monitored related to the administration of Seroquel. c. Review of the progress notes from the 1/25/22 Seroquel order date to current showed the only behaviors identified were confusion related to looking for his/her sister, and staying on the floor. No aggressive behaviors were documented. d. Interview with the power of attorney (POA) on 3/30/22 at 10:28 AM showed s/he had spoken with facility staff about the resident taking Seroquel, and believed the Seroquel was ordered for depression and yelling out at staff. The POA did not believe the resident was physically aggressive toward anyone, which included staff and other residents.	F 758	04/01/22 to assess those residents on psychotropic medications to confirm they are free from unnecessary medications and appropriate target behaviors are documented. 3. DNS/designee will educate licensed nurses on the requirement of target behavior documentation and monitoring. DNS/Designee will complete ongoing audits weekly times three months to identify other concerns related to unnecessary psychotropic medications as well as the documentation of target behaviors. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly 3 months (90 days) for further recommendations.	

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F 758	Continued From page 10 e. Review of the care plan showed the facility failed to formulate a plan to identify, monitor, or address any behaviors associated with antipsychotic medication use. f. Interview with the DNS on 3/30/22 at 10:30 AM revealed the resident likely did not need Seroquel, and she would attempt to have the order discontinued. She confirmed the resident was not physically aggressive with staff or other residents.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a clean environment in the kitchen. The findings were:	F 812	1. Countertop, cabinet, shelving, and floor surfaces identified during survey are sanitizable. This includes repair/replacement of areas cited	5/14/22

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F 812	Continued From page 11 The following concerns were identified during kitchen observations, which created uncleanable surfaces: a. On 3/30/22 at 2:25 PM observation showed a chipped area around the front handwashing sink at the front left edge. The left side of that area had a 26 inch damaged area that exposed the wood underneath. At the right corner from the handwashing sink, a hardened brown material was on the wall from the floor to 4 feet high, and was 3 inches across. Three floor tiles were missing under the 3 compartment sink. The area was blackened with dirt and debris. An additional tile was missing on the floor by the pots and pans storage area, and was noted to be blackened with dirt and debris. b. On 3/30/22 at 2:33 PM a floor tile was noted to be chipped out in the pantry area that measured 4 inches by 2 inches, and was blackened with dirt and debris. c. On 3/30/22 at 2:40 PM 3 cabinet doors below the microwave were noted to have peeled off paint. Two floor tiles under the Vulcan Steamer were noted to be chipped with multiple small chips. They were blackened with dirt and debris. Other various small chipped areas over the length and width of the kitchen floor were noted to be blackened with dirt and debris. Interview in the main dining area with the maintenance director on 3/30/22 at 10:51 AM confirmed he was aware of the issues with the kitchen floors, cabinet doors, and sink area, and the facility had attempted to get bids for repairs to the kitchen. However, he revealed the facility failed to have a written plan with a timeframe to start and complete those repairs. Interview with the certified dietary manager on 3/30/22 at 5:01 PM confirmed the areas in the kitchen that were	F 812	including countertops in dining hall adjacent to kitchen, countertops in kitchen, cabinets in dining hall adjacent to kitchen and inside kitchen, shelving in back storage area of kitchen, and floor surface in kitchen. 2. Audit completed by Executive Director on 04/01/22 to assess for other concerns related to a clean environment in the kitchen with any other concerns added to the repair/replace log. 3. Executive Director will educate maintenance and dietary staff on the requirement that all kitchen surfaces are in good repair, clean, and sanitizable. Executive Director will complete weekly kitchen audits times three months to assess for a clean kitchen environment as well as for needed repairs/replacements. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly x 3 months (90 days) for further recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD THERMOPOLIS, WY 82443

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F 812	Continued From page 12 in need of repair were damaged, making cleaning them a challenge.	F 812		
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 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 ensure 1 of 1 sample residents (#24) who received antibiotic therapy had a stop date or documented rationale for antibiotic therapy with no stop date. The findings were: Review of the 2/11/22 quarterly MDS assessment showed resident #24 was admitted to the facility on 11/19/21 with diagnoses which included Alzheimer's dementia, end stage renal disease, and obstructive uropathy. The review showed the resident had an indwelling urinary catheter. The following concerns were identified: a. Review of the physician orders showed the resident had a 1/29/22 order for cephalexin (antibiotic) 250 milligrams by mouth once daily for personal history of urinary tract infections. Further review showed the order failed to have an end date, or duration, for administration. b. Review of progress notes, January/February/March 2022 medication	F 881	1. Primary care physician stopped antibiotic 4/22/22. 2. Audit completed by DNS/Designee on 04/01/22 to assess for other residents who may be on antibiotics have in place appropriate stop dates or a risk/benefit statement from their Physician. 3. DNS/designee will educate licensed nurses on the requirement of proper antibiotic stewardship related to the use of antibiotics. DNS/Designee will complete ongoing audits weekly times three months to ensure those residents on antibiotics have a stop date or have a risk/benefit statement from their Physician. 4. Results of initial and ongoing audits will be reviewed via the QAPI process monthly x 3 months (90days) for further recommendations.	5/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 03/31/2022

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F 881	Continued From page 13 administration record, and the entire medical record showed no documented rationale for continued antibiotic therapy without an end date. c. Interview with the DNS on 3/30/22 at 10:28 AM confirmed there was no documented rationale from the physician for an ongoing order for antibiotic therapy with no end date. d. Review of the facility policy titled, "Antimicrobial Stewardship Program (ASP)," last updated March 2018, showed the following, "...2. Accountability...b. Center and Providers...Document clinical rationale to support use of antibiotics, if using outside current clinical guidelines."	F 881		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	535051	A. BUILDING: _____ B. WING _____	3/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNES	**1210 CANYON HILLS RD THERMOPOLIS, WY**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 1 of 13 sample residents (#31). The findings were: 1. Review of the 2/28/22 admission MDS assessment for resident #31 showed s/he was admitted to the facility on 2/23/22 for aftercare following surgery on the circulatory system. Further review showed the resident was coded as receiving an anticoagulant for 6 days of the 7-day look-back period. The following concerns were identified: a. Review of a physician order dated 2/23/22 showed the resident was prescribed 75 milligrams of clopidogrel bisulfate (antiplatelet medication) daily. Further review of the medical record showed no evidence the resident had been prescribed an anticoagulant. b. Interview with the MDS coordinator on 3/31/22 at 9:17 AM confirmed the resident had not received an anticoagulant and she was unaware the medication clopidogrel was not coded as an anticoagulant. 2. According to the MDS 3.0 RAI Manual version 1.71.1 page 472 "N0410E, Anticoagulant...record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here."

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

The above isolated deficiencies pose no actual harm to the residents