STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET CHEYENNE, WY 82001**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/27/22 to 7/1/22. Also reviewed in the course of the survey were complaint intakes WY00003402, WY00003405, and WY00003430. 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 this document: ADL: Activities of Daily Living ADON: Assistant Director of Nursing ARD: Assessment Reference Date BIMS: Brief Interview for Mental Status CMS: Centers for Medicare and Medicaid Services CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse mg: Milligrams MDS: Minimum Data Set NHA: Nursing Home Administrator OBRA: Omnibus Budget Reconciliation Act RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 606 SS=D	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	F 606		7/19/22

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

Electronically Signed | 07/28/2022

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F 606	Continued From page 1 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, 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 file review and staff interview, the facility failed to ensure the state nurse aide registry was reviewed for any findings of abuse, neglect, exploitation, mistreatment, or misappropriation prior to resident contact for 1 of 2 CNAs (CNA #4) reviewed. The findings were: Review of the employee file for CNA #4 showed her date of hire was 4/27/22. The review showed no evidence the CNA registry was checked prior to the CNA working independently with residents. Interview with the human resource manager and the NHA on 6/29/22 at 3:50 PM confirmed the facility failed to ensure the CNA registry was checked prior to CNA #4 working with residents.	F 606	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Staff # 4 CNA registry was reviewed and placed in HR file 6/29/22 by HR director, no finding of abuse, neglect, exploitation, mistreatment or misappropriation. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The HR Director reviewed on 6/29/22 all CNA files to ensure that the correct CNA registry was reviewed and placed in the	

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F 606	Continued From page 2	F 606	HR file, no other CNAs identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The NHA and HR Director were educated by Interim DON on 7/19/22 that each new hire CNA must have a CNA registry, this must be reviewed and placed in the HR file prior to staff hire. The HR Director will run the CNA registry on all new CNA hires. The NHA will review all new CNA hire packets to ensure the CNA registry was completed. The HR Director/Designee will audit weekly for three months all CNA new hire packets to confirm the CNA registry was run, reviewed and placed in the HR file. Any identified concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The HR Director/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The HR Director will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of	

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F 606	Continued From page 3	F 606	audits.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		7/22/22

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F 623	Continued From page 4	F 623		

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy

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F 623	Continued From page 5 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer for 7 of 7 sample residents (#32, #35, #49, #53, #57, #61, #64) reviewed for facility-initiated transfers. The findings were: 1. Review of the medical record showed resident #32 was transferred to the hospital and admitted on 6/23/22 for an acute change of condition following a fall. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative or notified the ombudsman. 2. Review of the medical record showed resident #35 was transferred to the hospital on 2/25/22 following an acute change of condition and	F 623	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #32 did not return to the facility. Resident #35 returned to the facility on 3/2/22. Resident #49 returned to the facility on 4/24/22. Resident #53 returned to the facility on 5/13/22. Resident #57 returned to the facility on 6/30/22. Resident #61 returned to the facility on 6/13/22. Resident #64 returned to the facility on 6/26/22.	

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F 623	Continued From page 6 readmitted to the facility on 3/2/22. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative or notified the ombudsman. 3. Review of the medical record showed resident #49 was transferred to the hospital on 4/21/22 for an acute change of condition and readmitted to the facility on 4/24/22. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative or notified the ombudsman. 4. Review of the medical record showed resident #53 was transferred to the hospital on 4/30/22 for an acute change of condition. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative or notified the ombudsman. 5. Review of the medical record showed resident #57 was transferred to the hospital on 6/18/22 for an acute change of condition. Further review showed no evidence the facility issued a written transfer notice to the resident or the resident's representative or notified the ombudsman. 6. Review of the medical record showed resident #61 was transferred to the hospital on 6/5/22 following an acute change of condition and readmitted on 6/13/22. Further review showed no evidence to the facility the facility issued a written transfer notice to the resident or the resident's representative or notified the ombudsman. 7. Review of the medical record showed resident #64 was transferred to the hospital on 6/10/22 after an acute change of condition and readmitted on 6/26/22. Further review showed no evidence	F 623	II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Interim DON reviewed all residents currently at the hospital on 7/22/22, no residents currently at the hospital. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education was provided by SDC/Designee starting on 7/19/2022 to licensed nurses on providing transfer notice to each resident upon transfer to the hospital. The SSD was educated on 7/22/22 to notify the ombudsman of all transfers. The transfer notice will be given to each resident upon transfer to the hospital, in cases of emergency the notice will be sent to the resident/responsible party no later than 24 hours after the transfer. The SSD will notify the ombudsman of all transfers as soon as practicable. The HIM/Designee will review all transfers to ensure transfer notice was given and ombudsman notified ongoing. The HIM/Designee will audit weekly for 3 months all transfers to verify transfer notice and ombudsman notification was completed. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO	

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F 623	Continued From page 7 the facility issued a written transfer notice to the resident or the resident's representative or notified the ombudsman. 8. Interview with the NHA on 6/30/22 at 4:01 PM revealed he was unable to locate the transfer notices. 9. Review of policies and procedures provided by the facility showed a MED-Pass, Inc. (Revised March 2017) "Transfer Form" and "Transfer Agreement" document that failed to include a procedure for issuing a written notice to the resident or the resident's representative of the transfer and a procedure for notifying a representative of the Office of the State Long-Term Care Ombudsman.	F 623	MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The HIM/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The HIM will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		7/22/22

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F 625	Continued From page 8 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to provide written information on the bed-hold policy for 7 of 7 (#32, #35, #49, #53, #57, #61, #64) sample residents reviewed for facility-initiated transfers. The findings were: 1. Review of the medical record showed resident #32 was transferred to the hospital and admitted on 6/23/22 for an acute change of condition following a fall. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 2. Review of the medical record showed resident #35 was transferred to the hospital on 2/25/22 following an acute change of condition and readmitted to the facility on 3/2/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 3. Review of the medical record showed resident #49 was transferred to the hospital on 4/21/22 for	F 625	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #32 did not return to the facility after hospitalization on 6/23/22. Resident #35 returned to the facility on 3/2/22. Resident #49 returned to the facility on 4/24/22. Resident #53 returned to the facility on 5/13/22. Resident #57 returned to the facility on 6/30/22. Resident #61 returned to the facility on 6/13/22. Resident #64 returned to the facility on 6/26/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Interim DON reviewed all residents currently at the hospital on 7/22/22, no	

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F 625	Continued From page 9 an acute change of condition and readmitted to the facility on 4/24/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 4. Review of the medical record showed resident #53 was transferred to the hospital on 4/30/22 for an acute change of condition. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 5. Review of the medical record showed resident #57 was transferred to the hospital on 6/18/22 for an acute change of condition. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 6. Review of the medical record showed resident #61 was transferred to the hospital on 6/5/22 following an acute change of condition and readmitted on 6/13/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization. 7. Review of the medical record showed resident #64 was transferred to the hospital on 6/10/22 after an acute change of condition and readmitted on 6/26/22. Further review showed no evidence the facility issued written information on the bed-hold policy to the resident or the resident's representative at the time of the hospitalization.	F 625	residents currently at the hospital. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education was provided by SDC/Designee starting on 7/19/2022 to licensed nurses on providing bed hold policy to each resident upon transfer to the hospital. The bed hold policy will be given to each resident upon transfer to the hospital, in cases of emergency the notice will be sent to the resident/responsible party no later than 24 hours after the transfer. The HIM/Designee will review all transfers to ensure bed hold policy was given. ongoing. The HIM/Designee will audit weekly for 3 months all transfers to verify bed hold policy was completed. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The HIM/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The HIM will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing	

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F 625	Continued From page 10 8. Interview with the NHA on 6/30/22 at 9:55 AM revealed he was unable to locate the bed-hold notices. 9. Review of an undated "Bed Hold Policy-Written Notification" letter written by the NHA showed "A copy of the Bed Hold Authorization is provided to the resident at the time of transfer to the hospital or on therapeutic leave. In case of emergency transfer, written notice to the resident and/or responsible party is provided within 24 hours of the transfer." Interview with the NHA on 6/30/22 at 3:37 PM confirmed the facility did not have a Bed-Hold policy so he had written the letter describing the facility's procedure.	F 625	frequency of audits.	
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.	F 636		7/25/22

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F 636	Continued From page 11 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (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.	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 636	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI manual version 3.0, the facility failed to ensure comprehensive assessments were completed not less than once every 12 months for 2 of 23 sample residents (#1, #8) reviewed for timely comprehensive MDS completion. The findings were: 1. Review of the medical record for resident #1 showed s/he was admitted to the facility on 6/3/22. Review of the 6/9/22 MDS admission assessment showed the assessment and associated care area assessments (CAAs) were to be completed by 6/16/22. The following concerns were identified: a. Review of the 6/9/22 admission MDS assessment reviewed on 6/28/22 at 12:59 PM showed sections A, B, C, D, E, G, GG, H, I, J, L, M, N, O, P, Q, and V were listed as "In progress" (25 days from admission and 11 days past due). 2. Review of completed MDS assessments showed the most recent comprehensive assessment completed and accepted for resident #8 was an annual MDS assessment dated 6/2/21. Further review showed an annual MDS assessment dated 5/17/22 was "in progress" and had not been completed, submitted, or accepted. 3. Interview with the ADON on 7/1/22 at 9:27 AM revealed comprehensive assessments should be performed at admission, with significant change, or annually. 4. Interview with the MDS coordinator on 7/1/22 at 10:05 AM confirmed comprehensive MDS assessments were required to be performed	F 636	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 1 Admission MDS was completed on 7/13/22. Resident #8 Annual MDS was completed on 7/6/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: MDS schedule was reviewed for any overdue comprehensive assessments by the interim DON on 7/25/22. No overdue comprehensive assessments were identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The MDS Coordinator was educated on timely comprehensive MDS completion by the interim DON on 7/25/22. The MDS will review the MDS schedule and complete all MDS timely. The NHA/Designee will review the MDS schedule weekly for three months to ensure there are no overdue comprehensive assessments. Any concerns will be addressed immediately.	

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F 636	Continued From page 13 upon admission, annually, and with significant changes. Further interview revealed the assessment must be completed within 14 days of the assessment reference date. 5. Review of the "CMS RAI version 3.0 manual, October 2019" showed "...The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment...The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days)...The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD +14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than..."	F 636	IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The MDS Coordinator/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The MDS Coordinator will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI manual version 3.0, the facility failed to ensure quarterly MDS assessments were completed not less than every 92 days for 11 of 23 sample residents (#9, #10,	F 638	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	7/25/22

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F 638	Continued From page 14 #11, #12, #13, #16, #17, #29, #50, #51, #66) reviewed for timely quarterly MDS assessment completion. The findings were: 1. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #11 was a quarterly MDS assessment dated 2/16/22 and the most recent comprehensive MDS assessment completed and accepted was dated 7/14/21. Further review showed an annual MDS assessment dated 5/16/22 was "in progress" and had not been completed, submitted, or accepted. 2. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #50 was a quarterly MDS assessment dated 2/19/22. Further review showed a quarterly MDS assessment dated 5/22/22 and a quarterly MDS assessment dated 6/24/22 were "in progress" and had not been completed, submitted, or accepted. 3. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #16 was a quarterly MDS assessment dated 2/21/22. Further review showed a quarterly MDS assessment dated 5/24/22 and a death in facility MDS assessment dated 6/14/22 were "in progress" and had not been completed, submitted, or accepted. 4. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #66 was an annual MDS assessment dated 2/18/22. Further review showed a quarterly MDS assessment dated 5/21/22 and a quarterly MDS assessment	F 638	Resident # 9 discharged to community on 6/24/22, the discharge MDS was completed on 7/19/22. Resident # 10 quarterly MDS completed on 7/6/22. Resident # 11 annual MDS completed on 7/6/22. Resident #12 quarterly MDS completed on 7/6/22. Resident # 13 quarterly MDS completed on 7/13/22. Resident #16 discharged on 6/14/22, the discharge MDS was completed on 7/6/22. Resident #17 quarterly MDS completed on 7/6/22. Resident #29 quarterly MDS completed on 7/6/22. Resident #50 quarterly MDS completed on 7/6/22. Resident #66 quarterly MDS completed on 7/11/22 II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: MDS schedule reviewed on 7/25/22 by interim DON, no overdue quarterly assessments identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The MDS Coordinator was educated on timely quarterly MDS completion by the interim DON on 7/25/22. The MDS will	

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F 638	Continued From page 15 dated 5/26/22 were "in progress" and had not been completed, submitted, or accepted. 5. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #9 was a quarterly MDS assessment dated 2/14/22. Further review showed a quarterly MDS assessment dated 5/17/22, a quarterly MDS assessment dated 5/20/22, and a discharge return not anticipated dated 6/24/22 were "in progress" and had not been completed, submitted, or accepted. 6. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #12 was a quarterly MDS assessment dated 2/19/22. Further review showed a quarterly MDS assessment dated 5/19/22 was "in progress" and had not been completed, submitted, or accepted. 7. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #51 was a quarterly MDS assessment dated 2/14/22. Further review showed a quarterly MDS assessment dated 5/17/22, a quarterly MDS assessment dated 6/6/22, and an annual MDS assessment dated 6/20/22 were "in progress" and had not been completed, submitted, or accepted. 8. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #13 was a quarterly MDS assessment dated 2/15/22. Further review showed a quarterly MDS assessment dated 5/18/22, a quarterly MDS assessment dated 6/7/22, and a quarterly MDS	F 638	review the MDS schedule and complete all MDS timely. The NHA/Designee will review the MDS schedule weekly for three months to ensure there are no overdue quarterly assessments. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The MDS Coordinator/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The MDS Coordinator will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	

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F 638	Continued From page 16	F 638		

assessment dated 6/16/22 were "in progress" and had not been completed, submitted, or accepted.

9. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #10 was a quarterly MDS assessment dated 2/17/22. Further review showed a quarterly MDS assessment dated 5/20/22 was "in progress" and had not been completed, submitted, or accepted.

10. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #29 was a quarterly MDS assessment dated 2/14/22. Further review showed a quarterly MDS assessment dated 5/17/22, a quarterly MDS assessment dated 5/20/22, and a quarterly MDS assessment dated 7/5/22 were "in progress" and had not been completed, submitted, or accepted.

11. Review of completed MDS assessments showed the most recent OBRA assessment completed and accepted for resident #17 was a quarterly MDS assessment dated 2/21/22. Further review showed a quarterly MDS assessment dated 5/24/22 was "in progress" and had not been completed, submitted, or accepted.

12. Interview with the ADON on 7/1/22 at 9:27 AM revealed quarterly MDS assessments should be completed no more than 92 days after the previous OBRA assessment's ARD date.

13. Interview with the MDS coordinator on 7/1/22 at 10:05 AM confirmed quarterly assessments not completed within 92 days of the previous OBRA assessment were late. Further she revealed the facility had identified the late MDS assessments,

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F 638	Continued From page 17 and developed a performance improvement plan; however, the plan had not yet been fully implemented. 14. Review of the "CMS RAI version 3.0 manual, October 2019" showed "...The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type..."	F 638		
F 641 SS=E	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 medical record review and staff interview, the facility failed to ensure the MDS assessment information was an accurate reflection of resident status for 7 of 19 sample residents (#27, #32, #46, #49, #55, #57, #58). The findings were: 1. Review of the 3/25/22 quarterly MDS assessment showed the cognitive assessment for resident #27 had not been completed. 2. Review of the significant change MDS	F 641	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 27 BIMs/PHQ9 were completed 4-25-22, care plan reviewed 7/26/22. Resident # 32 did not return after last hospitalization. Resident # 46 BIMs/PHQ9 was completed 6/23/22, care plan reviewed	7/26/22

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F 641	Continued From page 18	F 641		

assessment dated 2/13/22 showed the cognitive assessment for resident #32 had not been completed.

3. Review of the quarterly MDS assessment dated 3/30/22 showed a cognitive assessment for resident #46 had not been completed.

4. Review of the 3/13/22 annual MDS assessment and the 4/5/22 quarterly MDS assessment showed the cognitive and mood assessments for resident #49 had not been completed.

5. Review of the 4/7/22 quarterly MDS assessment showed the cognitive assessment for resident #55 had not been completed.

6. Review of the 5/6/22 quarterly MDS assessment showed the cognitive assessment for resident #57 had not been completed.

7. Review of the 4/12/22 quarterly MDS assessment showed the cognitive assessment for resident #58 had not been completed.

6. Interview with the ADON on 7/1/22 at 9:27 AM revealed a BIMS assessment should be performed quarterly and if the resident was unable to participate, then a score of at least 0 or 99 should be indicated. If the area had a dash, the resident was not assessed and the assessment would not be considered complete.

7. Interview with the MDS coordinator on 7/1/22 at 10:05 AM confirmed the MDS assessment did not contain the required assessments. The MDS coordinator stated the absence of the assessments had been identified and an action

7/26/22.
Resident # 49 BIMs/PHQ9 was completed 7/25/22, care plan reviewed 7/26/22.
Resident # 55 BIMs/PHQ9 was completed 7-7-22, care plan reviewed 7/26/22.
Resident # 57 BIMs/PHQ9 was completed 7-25-22, care plan reviewed 7/26/22.
Resident # 58 BIMs/PHQ9 was completed 7-7-22, care plan reviewed 7/26/22.

II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

Review of all residents to ensure that a BIMS/PHQ9 has been completed within the last quarter, 5 residents identified for each assessment. Assessments completed and care plan reviewed for those residents identified by the MDS Coordinator on 7/26/22.

III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:

The MDS Coordinator was educated that a PHQ9 and BIMs is required in the 7 day lookback period for all quarterly and comprehensive MDS assessments. Education was provided by the interim DON on 7/25/22. The MDS coordinator will delegate and ensure BIMS/PHQ9 assessments are completed within the timeframe required.

NHA/Designee will audit weekly each

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F 641	Continued From page 19 plan was in place to correct the deficiency; however, it had not been fully implemented.	F 641	MDS assessment to ensure BIMS/PHQ9 were completed and included in the MDS. Any concerns will be identified immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The MDS Coordinator/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The MDS Coordinator will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	
F 656 SS=E	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	F 656		7/25/22

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F 656	Continued From page 20 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, resident, staff interview, and resident representative interview, and medical record review, the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 19 sample residents (#1, #15, #46, #61). The findings were: 1. Interview with resident #1 on 6/27/22 at 3:46 PM revealed s/he had been admitted to the facility on 6/3/22 in order to gain enough strength to live independently. Observation of the resident	F 656	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 1 Comprehensive care plan review completed on 6/29/2022, 6/9/22 MDS assessment completed on 7/13/22. Resident #15 Hospice care plan initiated on 7/22/2022. Bowel care plan updated on 7/18/2022.	

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F 656	Continued From page 21 at that time showed s/he used supplemental oxygen, appeared underweight, and could ambulate and transfer independently. Review of the resident's medical record showed the resident was administered an antipsychotic, an antianxiety, an opioid, a diuretic, and three antidepressant medications. The following concerns were identified: a. Review of the 6/9/22 admission MDS assessment showed it was incomplete. b. Review of the resident's care plan showed entries from a previous stay with a discharge date of 8/27/21, with the exception of activities which had been updated on 6/9/22. c. Interview with the MDS coordinator on 7/1/22 at 10:22 AM confirmed the care plan for the resident's current admission had not been completed in a timely manner. In addition, she stated the facility had identified the deficiency and an action plan had been developed; however, it had not been fully implemented. 2. Review of the 2/10/22 quarterly MDS assessment showed resident #15 was admitted to the facility on 1/24/20 with diagnoses which included dementia. The review showed an advanced directive plan was initiated on 9/26/20 and revised on 6/26/22 which included the following, "[Resident #15] is seen by [hospice name] hospice." Review of the bowel tracking documentation for June 2022 showed bowel movements for the resident were documented on 6/4/22, 6/5/22, 6/9/22 (4 days), 6/14/22 (5 days), 6/22/22 (8 days), 6/25/22, and 6/28/22. The review showed all other days were documented as "no" for bowel movements. Review of the June 2022 medication administration record and treatment administration record showed no interventions were documented by staff for the	F 656	Resident #46 Bathing care plan was reviewed and updated on 7/22/22. Resident #61 Behavior care plan updated with individualized target behaviors and non pharm interventions on 7/22/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: An Audit was completed by IDT by 7/25/2022 for residents that have hospice services, bowel concerns, bathing preferences, and behavioral management needs. The identified resident's care plans were reviewed and updated. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The IDT was educated on comprehensive and individualized care plans by Vivage RN consultant on 7/22/22. The Comprehensive Care Plan will be completed timely after admission. Each department will include person centered care plans for each resident to include areas to meet the resident's medical, nursing and mental/psychosocial needs. The MDS coordinator will open a new review with each quarterly or comprehensive MDS. The IDT will review any changes in medical, nursing and mental/psychosocial needs with changes and update the resident's care plan as needed. The HIM/Designee will review weekly X 3	

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F 656	Continued From page 22 extended time periods the resident had not had a bowel movement. Review of the progress notes for June 2022 showed, with the exception of one note on 6/12/22 (progress note dated 6/12/22 and timed 9:17 AM when a nurse gave the resident a suppository after being alerted by a family member), no documentation regarding interventions by staff to address the resident's extended time periods between bowel movements, and no evidence the physician was notified. The following concerns were identified: a. Review of the care plan showed the facility failed to ensure the care plan identified the delineation of care between the facility and the hospice, and a plan for collaboration between the facility and the hospice. d. Interview with the resident's representative on 6/27/22 at 3:05 PM revealed the resident was constipated about 3 weeks ago and had to have a suppository. The representative revealed she had notified staff of the resident's abdominal pain which resulted in the suppository administration. The resident's representative had told staff the better way to track bowel issues with the resident was to assess bowel sounds, as the resident had impaired memory, and was not a reliable historian. c. Review of the resident's care plan for the focus of 'GI/Bowels' dated 2/8/22 and revised 3/4/22 showed the following goal: "The resident will have a normal bowel movement at least every 3rd day through the review date." The interventions were as follows: "...Follow bowel protocol for bowel management...Monitor medications for side effects of constipation. Keep physician informed of any problems. Record bowel movement pattern each day. Describe amount, color, and consistency." d. Interview with the DON on 6/29/22 at 3:58	F 656	months that any changes in medical, nursing and mental/psychosocial needs have been updated on the residents care plan, comprehensive care plans and reviews are completed timely. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The NHA will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	

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F 656	Continued From page 23	F 656		

PM revealed it was her expectation for staff to follow the care plan. She stated the facility no longer utilized a bowel protocol, and instead relied on a comprehensive and individualized plan to address the needs of each resident. She further stated it was her expectation for the staff to notify the physician if a resident failed to have a bowel movement within 3 days, then again on day 4 if the resident failed to have a bowel movement, and each day thereafter. She stated the facility had an agreement with the hospice for care, and did not realize the care plan should delineate the responsibilities between the facility and the hospice.

3. Review of the quarterly MDS assessment dated 3/30/22 showed resident #46 had a cognitive assessment which had not been completed and diagnoses which included anxiety disorder, depression, morbid obesity, need for assistance with personal care, weakness, and cognitive communication deficit. Further review showed the resident required extensive physical assistance of 1 person for personal hygiene and bathing. Review of the care plan last revised on 6/29/22 showed "...BATHING PREFERENCE: [resident #46] prefers to receive 2 showers each week. [Resident #46] will refuse showers at times citing [s/he] is anxious. Provider has ordered medication to help decrease these feelings to help facilitate more regular bathing..." The following concerns were identified:

a. Interview with the resident on 6/27/22 at 2:59 PM revealed the facility did not provide routine showers and the resident had to go 10 days or more without bathing.

b. Review of the bathing record for April, May and June 2022 showed the resident received a bath on 4/20, 8 days later on 4/28, 20 days later

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F 656	Continued From page 24 on 5/18, 3 days later on 5/21, 4 days later on 5/25, and 10 days later on 6/4. After 6/4, the resident received a bath at least every 4 days. Further review showed no evidence the resident was out of the facility or refused bathing between 4/20/22 and 6/4/22. 4. Review of the 5/18/22 admission MDS assessment showed resident #61 was admitted to the facility on 5/12/22 with a primary diagnosis of "other neurological conditions", diabetes mellitus, neurogenic bladder, depression, and respiratory failure. The resident was transferred to the hospital on 6/5/22 and readmitted to the facility on 6/13/22. Review of the current physician orders showed the resident was prescribed 100 mg trazadone HCl (antidepressant and sedative) at bedtime for insomnia and 15 mg aripiprazole (antipsychotic) daily for depression on 6/13/22. The care plan showed an initiation date of 6/15/22. The following concerns were identified: a. Review of the care plan showed the resident had a focus area for medications which included the antidepressant and the antipsychotic medications. However, there were no target behaviors or specific individualized non-pharmacological interventions identified. b. Interview with the MDS coordinator on 7/1/22 at 10:22 AM confirmed the care plan was incomplete. 5. Interview with the DON and chief of operations on 6/30/22 at 4:53 PM resident care plans should be developed related to residents' preferences and should be followed based on residents' preferences.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents	F 677		7/25/22

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F 677	Continued From page 25 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and performance improvement project (PIP) review, the facility failed to ensure baths or showers were provided routinely for 3 of 6 sample residents (#32, #46, #61) who required assistance with ADLs. The findings were: 1. Review of the significant change MDS assessment dated 2/13/22 showed resident #32 had a cognitive assessment which had not been completed and diagnoses which included cancer, wound infection, diabetes mellitus, hip fracture, other fracture, anxiety disorder, and depression. Further review showed the resident required extensive physical assistance of 1 person for personal hygiene and bathing. The following concerns were identified: a. Review of the resident's shower/bath documentation for April, May, and June 2022 showed the resident was bathed on 4/23/22, 5/7/22 (14 days), 5/21/22 (14 days), 5/28/22 (7 days) , 6/4/22 (7 days), 6/8/22, 6/10/22, 6/14/22, and 6/21/22 (7 days). The resident was then hospitalized on 6/23/22. Further review showed no evidence the resident was out of the facility or refused any shower/baths between 4/23/22 and 6/23/22. 2. Review of the quarterly MDS assessment dated 3/30/22 showed resident #46 had a cognitive assessment which had not been	F 677	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #32 did not return to the facility after hospitalization on 6/23/22. Resident #46 showered on 7-19-22. Resident #61 showered on 7-5-22. Resident was discharged on 7-6-22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents' bathing preferences completed by 7/25/22, care plans and tasks updated with preferences by the interim DON/Designee. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education on shower preferences and documentation to shower aides by the interim DON on 7/22/22. The DON/Designee will review shower documentation daily M-F, any residents	

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 677	Continued From page 26	F 677		

completed and diagnoses which included anxiety disorder, depression, morbid obesity, need for assistance with personal care, weakness, and cognitive communication deficit. Further review showed the resident required extensive physical assistance of 1 person for personal hygiene and bathing. The following concerns were identified:

a. Interview with the resident on 6/27/22 at 2:59 PM revealed the facility did not provide routine showers and the resident had to go 10 days or more without bathing.

b. Review of the shower/bath documentation for April, May and June 2022 showed the resident received a bath on 4/20/22, 4/28/22 (8 days), 5/18/22 (20 days), 5/21/22, 5/25/22, and 6/4/22 (10 days). After 6/4, the resident received a bath at least every 4 days. Further review showed no evidence the resident was out of the facility or refused bathing between 4/20/22 and 6/4/22.

c. Review of the care plan last revised on 6/29/22 showed "...BATHING PREFERENCE: [resident #46] prefers to receive 2 showers each week. [Resident #46] will refuse showers at times citing [s/he] is anxious. Provider has ordered medication to help decrease these feelings to help facilitate more regular bathing..."

3. Review of the 5/18/22 admission MDS assessment showed resident #61 was admitted to the facility on 5/12/22 with a primary diagnosis of "other neurological conditions", diabetes mellitus, neurogenic bladder, depression, and respiratory failure. The review showed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required the extensive assistance of 1 staff member for bathing. The following concerns were identified:

a. Interview with the resident on 6/28/22 at 9:42 AM revealed s/he had concerns related to

with no showers will be offered showers or alternatives. Residents with continued refusals will have preferences and care plans updated as needed.

The DON/Designee will audit weekly X 3 months all shower documentation to ensure showers are being completed per preferences. Any concerns will be addressed immediately.

IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:

The DON/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The DONwill be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.

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F 677	Continued From page 27	F 677		

the lack of showers.

b. Review of the resident's shower/bath documentation showed the resident received a shower on 6/14/22 and again on 6/29/22 (14 days).

c. Review of the resident's care plan initiated on 6/15/22 showed it was incomplete, reading "Resident prefers (specify: showers/bed baths) on (specify: days of week/shift?) and (has no preference of care giver type) prefers assistance with bathing to be provide by a (Specify: male/female)." In addition the care plan showed "BATHING/SHOWERING: The resident requires (specify: supervision, limited, extensive, dependent) with (blank) person assist with bathing.

4. Interview with CNA #1 on 6/28/22 at 9:14 AM revealed residents did not always get showers and baths timely because bath aides were pulled to the floor due to staffing issues.

5. Interview with CNA #2 on 6/30/22 at 11:55 AM revealed showers and baths were not always completed timely due to staffing issues. Interview with staff #1 on 6/30/22 at 12:04 PM revealed baths were delayed due to staffing issues.

6. Interview with the DON on 6/29/22 at 3:58 PM showed it was her expectation for staff to follow the care plan regarding resident preferences. Interview with the DON and corporate chief of operations on 6/30/22 at 4:38 PM confirmed the performance improvement project for showers and baths was still in process. The DON stated that staffing was identified as the issue in the root cause analysis. She confirmed the staffing numbers had not increased since identification of staffing concerns as the issue.

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F 677	Continued From page 28 7. Group interview with 5 residents on 6/28/22 at 2:08 PM revealed residents felt there was not enough staff and no showers had been given for the previous 2 days. 8. Review of the 6/1/22 Action Plan showed the following, "Identified Concern: Bathing not being consistently completed per schedule. Plan: Discussion with New Interim DON and shower aides on shower processes. IDT (interdisciplinary team) will review clinical alerts daily (M-F) for "no shower" and complete follow up as needed. Plan of care will be updated on resident preferences. Shower will be discussed at each care conference. Any changes to the plan of care will be updated. Review bathing concerns monthly in QAPI (quality assurance performance and improvement) and address new concerns PRN (as needed). Completion Date: Ongoing. Changes Needed with Action Plan: One shower aide last day 6/15/22. Shower rooms, shower days and shower aides changed due to mechanical lift issues causing increased refusals. Continuing to work with residents on preferences and care. 7/1/22 Restorative aides will be assigned to assist with showers in addition to the shower aide. Therapy services will also assist with showers when working with residents. All disciplines will communicate and document showers. Continued recruitment for additional shower aides."	F 677		
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	F 684		7/22/22

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F 684	Continued From page 29 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 medical record review, and resident representative and staff interview, the facility failed to ensure an effective bowel management program for 1 of 5 sample residents (#15) selected for bowel and bladder continence. The findings were: 1. Review of the 2/10/22 quarterly MDS assessment showed resident #15 was admitted to the facility on 1/24/20 with diagnoses which included dementia. The resident was coded as always continent of bowel, and not on a toileting program. Review of the resident's care plan, last revised 3/4/22, showed a focus with the following goal: "The resident will have a normal bowel movement at least every 3rd day through the review date." Interventions were as follows: "Encourage resident to sit on toilet to evacuate bowels if possible. Follow bowel protocol for bowel management. Impaction: break up stool with lubricated finger and remove gently with each episode. Follow with enema as ordered to clear bowel. Monitor medications for side effects of constipation. Keep physician informed of any problems. Record bowel movement pattern each day. Describe amount, color, and consistency." Review of physician orders showed the resident received Miralax 17 grams by mouth each Monday, Wednesday, and Friday for bowel management, starting on 5/6/22. The following concerns were identified:	F 684	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 15 had a bowel movement 7/20, 7/21. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Review of all other residents with no bowel movement greater than 3 days was completed by the interim DON on 7/22/22, identified residents bowel concerns were addressed immediately. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Nurses and CNAs were educated on bowel movement documentation to ensure that all bowel movements are charted every shift 7-18-22. The CNAs complete charting on bowel movement every shift. The DON/Designee reviews bowel movement documentation daily	

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F 684	Continued From page 30 a. Review of the bowel tracking documentation for June 2022 showed bowel movements for the resident were documented on 6/4/22, 6/5/22, 6/9/22 (4 days), 6/14/22 (5 days), 6/22/22 (8 days), 6/25/22, and 6/28/22. The review showed all other days were documented as "no" for bowel movements. Review of the June 2022 medication administration record and treatment administration record showed no interventions were documented by staff for the extended time periods when the resident did not have a bowel movement. b. Review of the nursing progress dated 6/12/22 and timed at 9:17 AM showed the resident's family member reported to nursing staff the resident was "grabbing [his/her] stomach and rocking back and forth. A suppository was administered at that time. c. Interview with the resident's representative on 6/27/22 at 3:05 PM revealed the resident had been constipated about 3 weeks ago and had to have a suppository. The resident's representative revealed she had notified staff of the resident's abdominal pain which resulted in the suppository administration. In addition the resident's representative had told staff the better way to track bowel issues with the resident was to assess bowel sounds, as the resident had impaired memory, and was not a reliable historian. d. Further review of the medical record showed no evidence the physician was contacted regarding the extended periods without a bowel movement. e. Interview with the DON on 6/29/22 at 3:58 PM revealed it was her expectation for staff to follow the care plan. However, she also stated the facility bowel protocol was no longer utilized, and the resident should have an individualized care	F 684	M-F and reports to the nurses to complete follow up and charting on residents that have not had a bowel movement. The provider is notified of concerns as needed. The DON/Designee will audit weekly X 3 months that the bowel movement audit was completed and follow up occurred. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The DON/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The DON will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	

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F 684	Continued From page 31 plan to address bowel movement interventions, and her expectation was for staff to follow that plan. She stated it was her expectation for the staff to notify the physician if a resident failed to have a bowel movement within 3 days, then again on day 4 if the resident failed to have a bowel movement, and each day thereafter.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, policy and procedure review, and review of the oxygen concentrator manufacturer's instructions, the facility failed to ensure maintenance of equipment for respiratory call was provided in accordance with manufacturer's instructions for 1 of 4 sample residents (#64) who required supplemental oxygen. The findings were: 1. Review of the 6/2/22 admission MDS assessment for resident #64 showed the resident required oxygen therapy and had a diagnosis of acute and chronic respiratory failure with hypoxia and unspecified interstitial pulmonary disease. The following concerns were identified: a. Observation on 6/27/22 at 11:27 AM	F 695	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 64's oxygen concentrator filter was cleaned on 7.1.22 by a night shift nurse. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents with a concentrator had filters cleaned on 7.1.22 by night shift nursing staff.	7/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 695	Continued From page 32 showed the filter of the Invacare Platinum 5 oxygen concentrator was covered with dirt and debris. An additional observation on 6/30/22 at 8:25 AM showed the filter remained in the same condition. 2. Interview with the DON and the corporate chief of operations on 6/30/22 at 4:38 PM revealed the contracted oxygen company was to provide maintenance on the oxygen concentrators and the nursing staff were to clean the filters once a month. At that time the corporate chief of operations observed the filter on resident #64's oxygen concentrator and confirmed the filter required cleaning. 3. Review of the 2001 MED-PASS, Inc. (Revised October 2010) policy titled Oxygen Administration failed to include a procedure for performing routine maintenance on the oxygen concentrators. 4. Review of the Invacare Platinum 5 oxygen concentrator manufacturer's instructions retrieved at http://www.invacare.com/product_files/1118353.pdf on 7/6/22 showed on page 32 Section 6... Routine Maintenance...Cleaning the Cabinet Filter...1. Remove each filter and clean at least once a week depending on environmental conditions..."	F 695	III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Night Shift nurses educated on cleaning oxygen concentrator filters weekly as designated on the TAR by the interim DON on 7/25/22. Orders for cleaning filters weekly were entered into PCC. The assigned nurse will complete cleaning of the Oxygen Concentrator filters as it is scheduled on the TAR. The DON/Designee will audit Weekly X 3 months the charting for cleaning filters was completed and the filter is clean, any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The DON/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The DON will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		7/22/22

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 756	Continued From page 33 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 34 Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure pharmacist recommendations were sent to the resident's physician for review and action for 1 of 5 sample residents (#49) reviewed for medications. The findings were: 1. Review of the 5/31/22 Medication Regimen Review for resident #49 showed the pharmacist and the psychoactive committee recommended the physician decrease the resident's Depakote (anticonvulsant) medication from 500 mg twice a day to 500 mg in the morning and 250 mg in the evening. Review of a 6/3/22 social service note showed "reviewed medications in psychotropics meeting. Nursing/Pharmacy to request GDR (gradual dose reduction) on depakote". Review of the medical record showed no evidence the physician had responded to the recommendation. 2. Interview with the DON on 7/1/22 at 11 AM revealed the facility had not submitted the recommendation to the physician. 3. Review of the MED-PASS, Inc. (Revised May 2019) policy titled "Medication Regimen Reviews" showed "...9. An "irregularity" refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences...12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it."	F 756	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #49 Depakote order was adjusted on 7.11.22 per the recommendation from the pharmacist and physician. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Review of last 6 months pharmacy recommendations to ensure completion on 7.19.22 by Interim DON. No other concerns were identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The DON was educated by the Vivage RN Consultant on 7/22/22 about completion of medication regimen review. The DON will pull drug regimen reviews monthly from link RX. The identified recommendations will be completed timely by the DON and Medical Provider. The Pharmacy recommendations will be uploaded to PCC upon completion. The HIM/Designee will audit monthly X 3 months that all recommendations from the medication regimen review were completed. Any concerns will be	

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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POLARIS REHABILITATION AND CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 756	Continued From page 35	F 756	addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The DON/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The DON will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	
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 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	F 758		7/28/22

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 758	Continued From page 36 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 and staff interview, the facility failed to ensure appropriate behavior monitoring and interventions were in place for 2 of 5 sample residents (#1, #61) reviewed for psychotropic medications. The findings were: 1. Review of the medical record for resident #1 showed s/he was admitted to the facility on	F 758	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 1 - The provider will review the resident's psychotropic medications by 7/28/22 and make any changes as needed. Target behavior monitoring	

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F 758	Continued From page 37 6/3/22. Review of the 4/12/22 history and physical report showed the resident had diagnoses which included anxiety and mild depression. Further review showed "Psychiatric: Insight: good judgement. Mental Status: normal, mood and affect and active and alert. Orientation: to time, place, and person. Memory: recent memory normal and remote memory normal." Review of the current physician orders showed the resident was prescribed 1 tablet of 50 mg of quetiapine fumarate (antipsychotic) in the morning for depression; two tablets of 50 mg of quetiapine fumarate at bedtime for depression; one tablet of 0.5 mg lorazepam (antianxiety) twice daily for increased anxiety due to shortness of breath; 15 mg of mirtazapine (antidepressant) daily for depression; one tablet of 50 mg of trazodone HCl (antidepressant and sedative) at bedtime for depression; and one 60 mg capsule of duloxetine HCl delayed release sprinkle (antidepressant and nerve pain) for major depressive disorder. The physician orders also showed the resident was to be observed for side effects related to the antipsychotic, antianxiety, and sedative/hypnotic medications. The following concerns were identified: a. Review of the 6/22/22 medication regimen review showed the resident was on the list of residents reviewed during the period of 6/1/22 to 6/30/22 which showed "Based on information available at time of review and assuming the accuracy and completeness of such information in the medical record, the following residents were reviewed with no current recommendations and/or comments and recommendations have been routed to respective reports." There was no evidence the duplicate therapy of medications administered for depression or the use of the antipsychotic for depression was addressed.	F 758	added on 7/28/22. Resident #61 - Target behaviors for abilify and trazodone were entered into PCC on 7/28/22 by the interim DON. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents with psychotropic medications reviewed that behavior monitoring and interventions are in place, completed by Interim DON by 7/25/22. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Nurse Managers were educated on 7/25/22 by the interim DON that each psychotropic medication needs behavior monitoring and interventions. The Behavior monitoring order will be placed in PCC. The nursing staff will complete TAR each shift. The DON/Designee will audit weekly X 3 months any additions or changes with psychotropic medications to ensure that behavior monitoring order was put in place. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:	

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F 758	Continued From page 38 b. Review of a 6/27/22 psychotropic medication management review form showed the resident received one medication for anxiety, and 4 medications for depression. The "Target Behavior" section was left blank. The "Baseline Status and Behavior" currently being manifested was documented as alert, cooperative, friendly, and isolative. Review of a 6/27/22 social services note showed "Resident reviewed during monthly GDR [gradual dose reduction], [the resident] is currently stable on his course of medication and no changes were recommended by the NP [nurse practitioner], DON, or Pharmacy." There was no evidence the duplicate therapy of medications administered for depression or the use of the antipsychotic for depression was addressed. c. Review of the medical record showed no evidence target behaviors for each medication had been identified and were being monitored. 2. Review of the 5/18/22 admission MDS assessment showed resident #61 was admitted to the facility on 5/12/22 with diagnoses which included depression. Review of the current physician orders showed the resident was prescribed 15 mg of apripiprazole (antipsychotic) daily for depression; and 100 mg of trazodone HCl (antidepressant and sedative) at bedtime for insomnia. Further review showed the resident was to be observed for side effects related to the antidepressant, antipsychotic, and sedative/hypnotic medications. The following concerns were identified: a. Review of the medical record showed no evidence target behaviors for each medication had been identified and were being monitored. 3. Interview on 6/30/22 at 4:38 PM with the DON and the corporate chief of operations confirmed	F 758	The DON/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The DON will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	

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F 758	Continued From page 39 the medical record lacked documentation of the identification of target behaviors and monitoring of each antipsychotic medication administered.	F 758		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for	F 790		7/25/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 790	Continued From page 40 dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, and medical record review, the facility failed to ensure dental services were provided for 1 of 19 sample residents (#1) reviewed for dental service needs. The findings were: 1. Review of the medical record showed resident #1 was admitted to the facility on 6/3/22 with diagnoses which included chronic obstructive pulmonary disease with acute exacerbation, generalized and unspecified protein-calorie malnutrition. Review of the 6/3/22 admission nursing assessment showed the resident was 73 inches tall and weighed 136.6 pounds. Interview with the resident on 6/27/22 at 3:46 PM revealed s/he had dentures and kept them in a chest of drawers. The resident stated s/he would like to learn how to use them; however, the dentures hurt his/her mouth. The following concerns were identified: a. Review of the 6/3/22 admission nursing assessment showed the resident "Has Own Teeth". b. Review of the 6/10/22 nutrition data assessment showed the resident had a "usual body weight" of 135 to 140 pounds for almost one year. Further review showed the resident "Has Own Teeth" and did not have any mouth pain. The dietitian's Summary/Plan/Progress note showed "...Weight maintenance or gain is preferred."	F 790	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #1 dentist appointment set for 7/25/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents interviewed for the need of dental services by Interim DON on 7/23/22, 7 residents identified to need additional dental services and appointments set for each resident. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The SSD was educated by the interim DON on 7/22/22 about reviewing ancillary services for all residents. The SSD will interview each resident on admission or with dental change on the need for dental ancillary services.	

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F 790	Continued From page 41 c. Interview with the dietitian on 6/29/22 at 2:29 PM revealed she had conducted her nutrition assessment remotely by using the data collected on the nursing assessment. The dietitian stated the dentition status of a resident would affect her evaluation. d. Interview with the DON and corporate chief of operations on 6/30/22 at 4:38 PM confirmed the nursing assessment was inaccurate and stated a dentist appointment had been made for the resident.	F 790	The SSD/Designee will audit weekly X 3 months that all new admissions and any residents with dental concerns were addressed and ancillary services offered. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The SSD/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The SDC will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	
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	F 812		8/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 42 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, staff interview, and review of the U.S. Public Health Service Food Code, the facility failed to ensure food was properly stored in 1 of 1 kitchen. In addition the facility failed to ensure proper hand hygiene during food preparation, and food temperatures were appropriate prior to placing on the steam table. The census was 60. The findings were: Related to food storage: 1. Observation on 6/27/22 at 9:15 AM showed a gallon-sized container, approximately 3/4 full, of "Kraft Creamy Caesar" dressing had an open date of 6/11/22 and was stored at room temperature in the dry storage area of the kitchen. The container was marked as "Refrigerate after Opening". An additional observation on 6/29/22 at 9:18 AM showed the container of dressing remained in the same location. Interview with the dietary manager at that time confirmed the container should have been refrigerated and discarded the dressing. Related to hand hygiene: 1. Observation on 6/29/22 at 9:40 AM showed cook #1 was preparing lasagna for the noon meal by using his gloved hands to place pasta on a pan of meat sauce. The cook removed his gloves and without performing hand hygiene donned	F 812	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Kraft Creamy Cesar identified during observation on 6/27/22 was disposed of on 6/29/22. Cook #1 was educated on hand hygiene and taking food temperatures before placing them on the steam table by the Food and Nutrition Manager on 7/22/22. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential to be affected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Educate Staff on proper storage for Refrigerated items on 8/16/22 by Administrator. Staff will store all refrigerated items in refrigerator after use	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 812	Continued From page 43 new gloves, touched his facemask, and continued to directly handle the pasta. The cook again adjusted his facemask and transferred the food to a food processor. The cook removed his gloves and without performing hand hygiene donned new gloves, opened the walk-in freezer, and returned with a cardboard box of frozen beef patties. The cook placed the raw beef patties onto a baking sheet with his gloved hands, removed his gloves, without performing hand hygiene donned new gloves, proceeded to season the beef patties, and then placed them in the oven. The cook continued following this pattern of doffing and donning gloves with no hand hygiene; directly touching food with his gloved hands; adjusting his facemask; and using his gloved hands to open the refrigerator until 10:04 AM when hand hygiene was performed. Related to food temperature: 1. Observation on 6/29/22 at 9:53 AM showed cook #1 was whisking potato pearls with hot water in a stainless steel container. Without checking the temperature of the potatoes the cook placed the potatoes directly on the steam table. 2. Observation on 6/29/22 at 9:58 AM showed cook #1 removed the beef patties from the oven and transferred the beef patties to a stainless steel container which contained hot water and a beef flavor base. Without checking the temperature of the meat the cook placed the beef patties directly on the steam table. 3. Observation on 6/29/22 at 10:02 AM showed cook #1 prepared pureed lasagna and transferred the altered lasagna to a stainless steel container. Without checking the temperature of the lasagna	F 812	and not allow prolonged exposure to items outside of appropriate window of use. Proper Food Storage techniques will be adhered to and if not they will be addressed by Dietary manager. Educate Kitchen Staff on hand hygiene and food temperatures on 7/22/22 by the food and nutrition manager. Staff will perform proper hand hygiene when don/doffing gloves and handling food. The food will be temped prior to going onto the steam table, any food outside of proper temperatures will be addressed. The FNM/designee will audit weekly X 3 months observation of hand hygiene and food temperature checks. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The FNM/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The FNM will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 812	Continued From page 44	F 812		

the cook placed the container directly on the steam table.

4. Interview with cook #1 on 6/29/22 at 10:35 AM revealed he was unaware food should not be put on the steam table until it had reached the appropriate temperature.

5. Interview with the dietitian on 6/29/22 at 2:57 PM confirmed the dietary staff required more education on hand hygiene and the proper use of gloves. In addition she stated food should be at the correct temperature for the type of food being prepared before it was placed on the steam table.

6. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and:
(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms;
(B) After using the toilet room;
(C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B);
(D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;
(E) After handling soiled EQUIPMENT or UTENSILS;
(F) During FOOD preparation, as often as necessary to remove soil and contamination and

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET CHEYENNE, WY 82001**

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F 812	Continued From page 45 to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands." 7. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54°C (130°F) or above; or (2) At 5ºC (41ºF) or less.	F 812		
F 880 SS=E	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 program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		8/3/22

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS REHABILITATION AND CARE CENTER	**2700 E 12TH STREET CHEYENNE, WY 82001**

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F 880	Continued From page 46 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 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 880	Continued From page 47 §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 review of facility reportable incidents, staff interview, review of the facility's COVID line list, and policy review, the facility failed to ensure infectious disease outbreaks were reported as required. The resident census was 60. The findings were: 1. Review of the facility's line list of COVID positive residents and staff, provided by the facility at the time of entrance, showed resident #63 tested positive for COVID on 5/24/22, cook #2 tested positive on 6/7/22, resident #57 tested positive on 6/18/22, the business office manager tested positive on 6/24/22, and CNA #5 tested positive on 6/24/22. 2. Review of the facility's reportable incidents from 5/1/22 to 7/1/22 showed no evidence the facility reported an infectious disease outbreak to the state survey agency or state epidemiology. 3. Interview with the DON and clinical consultant on 7/1/22 at 11:24 AM revealed positive COVID results were to be reported to the state as an	F 880	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Implementation of infectious disease outbreak identification and reporting procedures, including but not limited to, all single cases and/or additional cases of Covid -19 among residents and staff. Covid-19 policy was revised on 7/1/2022. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential to be affected. The IP and DON, in conjunction with the IDT will review current covid-19 nursing facility guidelines from CDC and CMS.	

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F 880	Continued From page 48 outbreak and confirmed they were not reporting single cases of positive COVID results and did not report any cases identified in May or June 2022. 4. Review of the policy titled "Coronavirus Disease (COVID-19)-Testing Residents" last revised August 2020 showed "...8. The infection preventionist, or designee reports positive test results to the local or state health department (as appropriate) for contact tracing and to the CDC National Health and Safety Network (NHSN)."	F 880	The IP, DON and applicable IDT members will evaluate the facility□s overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. The IDT met on 7/22/22 to review CMS and CDC guidelines as well as current deficient practice. Areas identified for correction are Covid Reporting, Covid testing and Vaccine exemption policy. A Plan of Correction is in place for each identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: 1. Root Cause Analysis to identify and address the reasons for non compliance related identification and reporting infectious disease outbreaks. 2. The DON and IP will ensure education is provided for all staff on identification and reporting of infectious disease outbreaks. Education was completed by the interim DON by 8/3/22. 3. The Facility leadership will contact the Mountain Pacific Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility. The facility contacted the QIO via email on 7/27/22.	

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F 880	Continued From page 49	F 880	IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Weekly for no less than 12 weeks, the IP, DON and applicable IDT will conduct on-going monitoring via observation and line listing audits to ensure staff are complying with requirements for. a. Screening, identification and reporting of infectious disease outbreaks. After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the QAPI committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring which demonstrates sustained compliance	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including	F 886		7/22/22

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F 886	Continued From page 50	F 886		

but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with
COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 886	Continued From page 51 §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on review of the staff vaccine matrix, review of the CDC COVID data tracker, COVID testing log review, staff interview, policy and procedure review, and review of CMS guidance, the facility failed to ensure routine COVID surveillance testing was performed for staff with a vaccine exemption or temporary delay. The census was 60. The findings were: 1. Review of the COVID vaccine staff matrix provided by the facility on 6/27/22 showed 4 staff members with non-medical vaccine exemptions, 4 staff members with medical vaccine exemptions, and 1 staff member with a temporary delay/new hire. 2. Review of the CDC COVID data tracker showed the county transmission rate for the facility's location from 6/1/22 through 6/30/22 was "high." 3. Review of the facility's COVID testing logs from 6/1/22 through 6/27/22 showed testing was performed on 6/1/22, 6/8/22, 6/10/22, 6/15/22, 6/22/22, and 6/27/22; however, there was no evidence staff members with an exemption or	F 886	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Full round of covid testing for staff and residents completed on 7/1/22 II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents have the potential to be affected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The IP was educated on covid policy and required testing by interim DON on 7/22/22. The facility will continue to follow county positivity and test staff are required by CDC. Staff that are not testing as	

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F 886	Continued From page 52 temporary delay/new hire were tested bi-weekly. 4. Interview with the DON, ADON, chief of operations, and clinical consultant on 7/1/22 at 10:59 AM revealed the facility did not perform bi-weekly testing of staff members with an exemption or temporary delay. Further interview revealed the facility identified an action plan related to testing and confirmed it had not been fully implemented at that time. 5. Review of a policy titled "Coronavirus Disease (COVID-19)-Vaccination of residents and staff" last revised February 2021 showed no evidence of a facility process for testing individuals with a vaccine exemption or temporary delay. 6. Review of a policy titled "COVID-19 Prevention, Response, and Testing" last revised on 7/1/22 and provided by the DON on 7/1/22 at 12:26 PM showed "...5. Surveillance Testing...d. The facility will follow CMS guidance for surveillance testing based on community transmission rates..." Review of the "Surveillance Testing Interval Table" on page 4 showed healthcare personnel and ancillary non-medical service providers should receive twice weekly lab-based polymerase chain reaction [PCR] testing. If HCP (healthcare personnel) work infrequently at the facility, they should be tested within 3 days before their shift (including day of the shift)." Interview with the DON at that time revealed the policy was provided by the facility's consulting group and had not been implemented. 7. Review of the CMS QSO-20-38-NH, revised 3/10/22 showed the routine testing interval for staff who are not up-to-date on their COVID-19 vaccinations in a county with a high level of	F 886	required will be placed on leave until testing is completed. The IP/Designee will audit all testing weekly X 3 months to ensure that testing was completed as required by each staff member. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The IP/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The IP will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	

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F 886	Continued From page 53 COVID-19 community transmission is twice weekly.	F 886		
F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the	F 888		7/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 888	Continued From page 54	F 888		

facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/01/2022

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F 888	Continued From page 55 who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication:	F 888		

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F 888	Continued From page 56 §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on policy and procedure review and staff interview, the facility failed to ensure policies and procedures related to COVID-19 vaccination for staff members were developed with the minimum requirements. The census was 60. The findings were: Review of the COVID Policies titled "Coronavirus Disease (COVID-19) -Vaccination of Residents and Staff" dated February 2021 showed the following identified concerns: a. There was no policy and procedure ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated for COVID-19. b. There was no indication of contingency plans for staff that were not fully vaccinated for COVID-19. 2. Interview with the DON, ADON, chief of operations, and clinical consultant on 7/1/22 at 10:59 AM revealed the facility did not perform bi-weekly testing for staff members who had an exemption or temporary delay, unvaccinated staff were required to perform bi-weekly testing, staff were not allowed to work unless testing was performed, and staff members who did not	F 888	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A policy was reviewed and implemented on 7/1/2022. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The IP was educated on employee covid-19 vaccinations/exemptions on 7/22/22 by the interim DON. The IDT reviewed the Covid Vaccine Policy with Vivage RN Consultant on 7/22/22. The IDT will review and update policy as regulations and recommendations are	

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F 888	Continued From page 57 receive the vaccine were required to wear an N-95 or KN-95 mask with eye protection. 3. Interview with the DON 7/1/22 at 12:26 PM revealed the facility would implement consultant policies for COVID-19 and confirmed the consultant policies were not in use at that time.	F 888	changed from CDC or Wyoming Department of Health ongoing. The IP will audit Weekly X 3 months any regulations and recommendations are changed from CDC or Wyoming Department of Health. Any changes will be addressed immediatly. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The IP/designee will be responsible to report to the monthly Quality Assurance Performance Improvement (QAPI) Committee a summary of findings for review and recommendations for three months. The IP will be responsible to follow up on any recommendations made by the QAPI Committee. The QAPI will establish the necessity for ongoing frequency of audits.	