STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY REHABILITATION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/29/22 to 8/31/22. Also reviewed in the course of the survey were complaint intakes WY00003422 and WY00003424. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status CMS: Centers for Medicare and Medicaid Services CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 636 SS=E	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.	F 636		10/7/22

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

Electronically Signed | 09/23/2022

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F 636	Continued From page 1 §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (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	F 636		

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F 636	Continued From page 2 chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on review of the CMS Resident Assessment Instrument (RAI) manual version 3.0, medical record review, and staff interview, the facility failed to ensure comprehensive admission assessments were completed as required for 3 of 7 residents (#298, #300, #312) reviewed for comprehensive admission assessments. The findings were: 1. Review of the CMS RAI manual version 3.0 showed comprehensive assessments were to be completed within 14 days of admission. The following concerns were identified: a. Review of the medical record for resident #298 showed s/he was admitted on 8/4/22. Review of the admission MDS showed a completion date of 8/25/22, 7 days past due. b. Review of the medical record for resident #300 showed s/he was admitted 8/11/22. Review of the MDS 5 day assessment showed the assessment was still in progress. The completion due date was 8/25/22. c. Review of the medical record for resident	F 636	F636 S/S=E: Comprehensive Assessment and Timing 1)The MDS assessments for resident #298, #300, and #312 was completed and MDS assessments are in compliance according to regulation. 2)Audit of open MDS assessments, was completed by MDS/ADON, of upcoming MDS assessments to ensure completion is done on time. 3)Staff were educated on the completion date of MDS assessments to ensure completion in done on time per regulation. 4)The MDS Coordinator or designee will audit random MDS assessments to ensure completion is done on time. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	

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F 636	Continued From page 3 #312 showed s/he was admitted on 8/12/22. Review of the admission MDS assessment showed it had not been completed. The completion due date was 8/26/22. 2. Interview with the ADON on 8/30/22 at 1:48 PM confirmed the admission assessments were not completed within the 14 day timeframe. She stated they had one MDS coordinator who was in the hospital. She further stated they had another MDS coordinator they were training. She stated she and the corporate nurse were helping with the assessments.	F 636	5)Date of Compliance: 10/07/22	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the RAI manual, the facility failed to complete a significant change MDS assessment for 1 of 2 sample residents (#20) who required a significant change MDS assessment. The findings were:	F 637	F637 S/S=D: Comprehensive Assessment After Significant Change 1)MDS Significant Change assessment was completed on 10/12/21, for resident #20, when she was changed to comfort care measures. A significant change MDS was not completed when hospice services	10/7/22

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F 637	Continued From page 4 1. Review of the 12/31/21 quarterly MDS assessment for resident #20 showed the resident did not receive hospice services. Review of the medical record showed a 2/4/22 election of hospice benefit form. The following concerns were identified: a. Review of the medical record showed no evidence a significant change MDS assessment was completed after the resident started receiving hospice services. b. Review of the medical record showed the subsequent MDS assessment was a quarterly MDS assessment dated 3/18/22, which indicated the resident was receiving hospice services. c. During an interview on 08/31/22 at 10:52 AM the ADON confirmed the resident received hospice services and stated she was aware a significant change MDS assessment was required when a resident elected hospice. She further stated she was unsure why the assessment was missed. 2. Review of the "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual" by Centers for Medicare and Medicaid Services, October 2019, showed "...An SCSA [significant change in status assessment] is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD [assessment reference date] must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than)."	F 637	were started on February 4th, 2022, but was entered after deficiency was found. All other MDS assessments for resident #20 are current. 2)Audit of residents receiving hospice services was completed to ensure significant change MDS was completed upon start of hospice services. 3)Staff were educated on the need to open a significant change MDS assessment when hospice services are started, to ensure compliance per regulation. 4)The MDS Coordinator or designee will audit random MDS assessments to ensure completion is done when hospice services are started. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 10/07/22	
F 656 SS=E	Develop/Implement Comprehensive Care Plan	F 656		10/7/22

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F 656	Continued From page 5 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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.	F 656		

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F 656	Continued From page 6 (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 and staff interview, and medical record review, the facility failed to develop and/or implement a comprehensive care plan that addressed necessary care and treatment for 5 of 31 sample residents (#7, #26, #112, #135, #193) reviewed. The findings were: 1. Review of the 7/29/22 admission MDS assessment showed resident #112 was admitted to the facility on 7/22/22 with diagnoses that included unspecified open wound of the left foot. Further review showed the resident was cognitively intact with a BIMS score of 15 out of 15. Review of current physician orders showed a 3/9/22 order for skin assessments to be performed during the day shift every Monday, as well as an 8/9/22 order for "Wound Care: left lateral foot/pinky toe - monitor and apply skin prep as needed. (Currently covered with circular bandaid.) Notify wound care of any changes. Every shift, only wear shoes for transfers and therapy. Rubbing feet raw [due to] edema." The following concerns were identified: a. Observation of the resident on 8/29/22 at 1:15 PM showed the resident seated in his/her wheelchair with his/her left foot in a blue padded boot that extended halfway up his/her lower leg. Interview with the resident at that time revealed s/he wore the boot every day due to foot drop in both feet, with the left foot much worse than the right. The resident further stated s/he receives daily dressing changes to a wound s/he had on	F 656	F656 S/S=E: Develop/Implement Comprehensive Care Plan 1)Care Plans for residents #7, #26, #112, #135, and #193, have been updated to address necessary cares and treatments. 2)Audit of resident care plans was completed by IDT, to ensure accuracy of CPs. 3)Staff were educated on the need to update and change care plans as needed and upon admission. Also to be reviewed at care conference meetings to ensure they include necessary cares and treatments. 4)The DNS/Designee will audit random Care Plans to ensure accuracy of cares and treatments. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 10/07/22	

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F 656	Continued From page 7	F 656		

the left foot prior to the padded boot application.

b. Review of the current care plan, last revised 8/30/22, showed no documentation related to the padded boot. Further review showed a problem area stating the resident had "... actual impairment to skin integrity of the left lateral foot [related to] edema." However, this care area was not implemented until 8/30/22.

c. Interview with the DON and ADON on 8/31/22 at 2:16 PM confirmed the lack of documentation related to the padded boot, as well as the identified wound/skin integrity problem area.

2. Review of the 5/19/22 admission MDS assessment showed resident #7 was admitted to the facility on 5/12/22 with diagnoses that included pressure ulcer of sacral region, stage 4, as well as unspecified open wound, unspecified lower leg. Review of physician orders showed a 5/17/22 order for skin assessments to be performed during the day shift every Monday, as well as a 7/19/22 order for dressing changes to occur every Tuesday, Thursday, Saturday, and Sunday; this order was currently on hold. Continued review of physician orders showed a 7/28/22 order for wound care to the coccygeal/sacral area, as well as an 8/24/22 order for wound care to be performed to the resident's bilateral lower extremities during the day shift every other day. Review of the Weekly Skin Evaluation assessments showed on 7/7/22, wounds to the right and left rear lower legs were documented as "worsening." The following concerns were identified:

a. Observation of the resident on 8/29/22 at 3:08 PM showed the resident in his/her wheelchair wearing special shoes. The resident had dressings and padding placed between

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F 656	Continued From page 8	F 656		

his/her toes, as well as dressings in place to both of his/her lower legs.

b. Review of the resident's discontinued orders showed many different orders utilized in treatment of wounds to his/her bilateral lower extremities since his/her admission.

c. Review of the current care plan, last revised 7/8/22, showed no documentation related to the special shoes, or the dressings to both of his/her lower legs or between the toes.

d. Interview with the DON and ADON on 8/31/22 at 2:16 PM confirmed the lack of documentation in the care plan related to the resident's lower legs and feet.

3. Review of the 8/8/22 annual MDS assessment showed resident #135 had diagnoses which included arthritis, osteoporosis, vertebrogenic low back pain, scoliosis, cervicalgia, neuralgia and neuritis. Further, the pain medication section showed the resident should be assessed for pain, and was on scheduled and as needed pain medication. Review of the physician orders showed "monitor pain every shift indicate pain level and location, if applicable document non-pharmacological pain interventions." Further review of the physician orders showed the following medications were ordered for pain relief: Biofreeze gel 4%, Lidocaine patch 4%, Tramodol, and Tylenol. The resident had received opioid medications for 2 days out of the 7 day look back period. Review of the care area assessment (CAA) showed pain was not triggered. The following concerns were identified:

a. Interview on 8/29/22 at 9:06 AM with the resident revealed s/he had pain in the right hip and knee.

b. Review of the care plan failed to show a plan for pain.

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F 656	Continued From page 9	F 656		

c. Interview with the ADON on 8/31/22 at 12:27 PM revealed the resident did not have a care plan for pain, and should have.

4. Review of the 6/6/22 annual MDS assessment showed resident #26 had range of motion (ROM) limitations to one lower extremity and required supervision for ambulation. Review of the 6/6/22 activities of daily living (ADL) care area assessment (CAA) showed the resident had a healed fracture to the left lower leg and the resident was at risk for decline in ADLs. The CAA indicated a care plan would be developed to work with the resident to maintain the current level of functioning. Review of the current care plan provided by the facility on 8/31/22 at 9:30 AM showed the resident had a restorative program which included lower extremity exercises and ambulation 2 to 3 times per week. The following concerns were identified:

a. Review of the June 2022 restorative documentation showed only two dates documented (6/9/22 and 6/16/22); both were refusals.

b. Review of the July 2022 restorative documentation showed services were only provided on 7/5/22.

c. Review of the August 2022 restorative documentation showed services were only provided on 8/1/22.

d. During an interview on 8/31/22 at 10:52 AM the ADON confirmed restorative was not provided in accordance with the care plan.

5. Review of the 8/9/22 initial MDS assessment showed resident #193 had severe cognitive impairment (BIMS score of 6) and moderately impaired vision. Review of the 8/9/22 care area assessments (CAA) for visual function and

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F 656	Continued From page 10 cognitive loss/dementia indicated the facility was going to develop a care plan that addressed these areas. The following concerns were identified: a. Review of the care plan provided by the facility on 8/31/22 at 9:30 AM showed cognitive loss/dementia was not addressed (no problem, goals or interventions). Further review showed the care plan included a problem and a goal for impaired vision, but no interventions were included. b. On 8/31/22 at 10:52 AM the ADON confirmed the care plan did not have dementia/cognition addressed and stated the visual function care plan was incomplete and lacked interventions.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		10/7/22

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F 657	Continued From page 11 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure care plans were updated and revised for 1 of 31 sample residents (#102) reviewed. The findings were: 1. Review of the 7/25/22 quarterly MDS assessment showed resident #102 was admitted to the facility on 4/24/22 with diagnoses that included type I and type II diabetes mellitus. Review of the current care plan, last revised 4/25/22, showed a problem area described as "Skin: [the resident's] skin is intact ..." with interventions that included " ... staff to monitor for any potential skin breakdown" and "[The resident's] skin will be observed at least weekly by staff ..." The following concerns were identified: a. Review of current physician orders showed a 5/11/22 order to "Monitor rash to bilateral inner thighs. Cleanse and apply protective cream (calazyme or barrier cream) with each check and change. Every shift for heat rash from briefs." Further review showed a 6/24/22 order to "Monitor shearing to right buttock, apply barrier cream until resolved," as well as an 8/28/22 order for "Skin prep water blisters to right thigh every day until healed ..." b. Review of the current care plan showed no updated documentation related to the identified	F 657	F657 S/S=D: Care Plan Timing and Revision 1)Care Plan for resident #102 has been updated and revised to address necessary cares and treatments. 2)Audit of resident care plans was completed by IDT, to ensure accuracy of CPs. 3)Staff were educated on the need to update and change care plans as needed and upon admission. Also to be reviewed at care conference meetings to ensure they include necessary cares and treatments. 4)The DNS/Designee will audit random Care Plans to ensure accuracy of cares and treatments. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 10/07/22	

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F 657	Continued From page 12 skin issues, or their correlating physician orders. c. Interview with the DON and ADON on 8/31/22 at 2:16 PM revealed the care plan should have been updated to reflect the changes in the resident's skin condition.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and	F 676		10/7/22

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F 676	Continued From page 13 snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to ensure residents were given the treatment and services to maintain abilities in activities of daily living for 2 of 3 residents (#26, #79) reviewed for restorative care. The findings were: 1. Review of the 6/6/22 annual MDS assessment showed resident #26 was cognitively intact (BIMS score of 15) and required supervision for ambulation. Review of the 6/6/22 activities of daily living (ADL) care area assessment (CAA) showed the resident had a healed fracture to the left lower leg and the resident was at risk for decline in ADLs. The CAA indicated a care plan would be developed to work with the resident to maintain the current level of functioning. Review of the current care plan provided by the facility on 8/31/22 at 9:30 AM showed the resident had a restorative program which included "Ambulation with FWW [front wheel walker] x 15-20 minutes 2-3 x week as tolerated." The following concerns were identified: a. Review of the June 2022 restorative documentation showed only two dates documented (6/9/22 and 6/16/22); both were refusals. b. Review of the July 2022 restorative documentation showed services were only provided on 7/5/22. c. Review of the August 2022 restorative	F 676	F676 S/S= D: Activities Daily Living (ADLs)/Mntn Abilities 1)Restorative services are being provided to Residents #26 and #79 to ensure residents are given the treatment and services to maintain abilities in activities of daily living. 2)Audit of restorative programs was done to ensure residents are receiving services to appropriately meet their restorative needs and care plan. 3)Staff were educated to provide restorative services based on the restorative plan written and the needs of the resident. 4)The DNS/Designee will audit random Restorative Programs to ensure accuracy. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 10/07/22	

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F 676	Continued From page 14	F 676		

documentation showed services were only provided on 8/1/22.

d. During an interview on 8/29/22 at 1:36 PM the resident stated staff used to work with him/her on exercises and ambulation "...but not anymore."

e. During an interview on 8/31/22 at 10:52 AM the ADON stated in the past couple of months the restorative aides were pulled from their duties to work the floor as a CNA due to staffing challenges.

2. Review of the 7/11/22 admission MDS assessment showed resident #79 was cognitively intact (BIMS score of 15) and required extensive assistance with locomotion. Further review showed s/he had Occupational Therapy (OT) for 5 days, and Physical Therapy (PT) for 2 days. The expectation was to discharge back to the community. The CAA indicated a care plan for ADLs. The care plan showed "I have an ADL self-care performance deficit related to (r/t) impaired balance, limited mobility, arthritic pain, [Restorative]. I will improve current level of function in ADLs through the review date. PT/OT evaluation and treatment as per MD orders." The following concerns were identified:

a. Interview with the resident on 8/29/22 at 1:28 PM revealed s/he was not getting restorative aide help. The resident stated s/he wants to go home and "they are not helping me get better. The facility does therapy for the arms, and they would not continue therapy for legs. They [PT] said I was not progressing fast enough. They [PT] said I could do it on my own."

b. Review of 8/18/22 PT treatment notes showed "...Restorative nursing program written. Discharge summary completed."

c. Review of the restorative therapy notes showed a start date of 8/19/22, and failed to show

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F 676	Continued From page 15 the resident had received any restorative care. d. Interview on 8/31/22 at 10:52 AM with the ADON stated the restorative aides were pulled from their duties to work the floor as a CNA due to staffing challenges. Further, she stated the restorative program is not functioning as it should be right now.	F 676		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy	F 761	F761 S/S=E: Label/Store Drugs and	10/7/22

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F 761	Continued From page 16 and procedure review the facility failed to ensure medications were labeled with an open date, and medications available for use were not expired in 3 of 4 medication carts (Rapid Recovery cart B, East cart 1, West cart). The findings were: 1. Observation on 8/29/22 at 5:52 AM of the east hall medication cart showed 1 Lantus (insulin) flexpen 100 unit/milliliter (ml) was not dated with an opened date. Interview with RN #3 confirmed the injection pen was not dated and was for resident use. 2. Observation on 8/30/22 at 10:05 AM of the rapid recovery medication cart B showed 1 Novolog (Insulin Aspart) PenFill 100 unit/ml with no open date, and 1 Humalog (insulin) KwikPen 100 unit/ml with no open date written on the pen. Interview at that time with MAC #1 and unit manager #1 confirmed medications were for resident use, and should have been dated when they came out of the refrigerator. 3. Observation on 8/30/22 at 10:54 AM of the west station medication cart showed 1 Humalog KwikPen solution 100 unit/ml (Insulin Lispro) with no open date written on the pen. Interview with RN #2 at that time confirmed the pen had no open date written on it, and was for resident use. 4. Review of the policy and procedure "Medication Administration Subcutaneous Insulin" hand delivered by the administrator on 8/30/22 showed ..."5. Obtain insulin. Check expiration date. If refrigerated, allow warming to room temperature. Review manufacturer specific administration and storage instructions for pen devices. 6. Date vial or device after first use."	F 761	Biologicals 1)The opened and undated medications were discarded at the time of discovery by unit managers and DNS. 2)Initial audit completed of medication storage areas with any identified concerns corrected. Nurse management will ensure insulin pens are dated when they are removed from the refrigerator. 3)Staff were educated on expectations with medication labeling, handling, and storage. 4)DNS/Designee will audit medication carts to ensure compliance. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 10/07/22	

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F 839	Continued From page 17	F 839		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on employee file review, staff interview, and review of the "Nursys QuickConfirm License Verification Report", the facility failed to ensure professional staff had credentials to practice in accordance with State law for 1 of 2 (RN #4) professional license reviews. The findings were: 1. Review of the employee file for RN #4 showed the employee received a change in job status from LPN (licensed practical nurse) to RN (registered nurse) on 7/29/22. Review of the "Nursys QuickConfirm License Verification Report" showed the employee obtained an RN license in Colorado. Review of the Compact Status showed "Single State." Further review of the report showed "Nurse Licensure Compact (NLC) Information...Single state license: A license issued by a state board of nursing that authorizes practice only in the state of issuance..." 2. Interview with the DON on 8/31/22 at 10:30 AM revealed she believed that because Wyoming was a compact licensure state, nurses from Colorado could practice in Wyoming.	F 839	F839 S/S= D: Professional Staff 1)RN #4 license was questioned with the state board of nursing and multistate option was changed so he could practice in the state of Wyoming. Until this process is finalized, RN #4 will work as under his LPN license. 2)Employee files were audited to ensure staff were working with appropriate scope of practice within license requirements. 3)Staff were educated to ensure license is within scope of practice and staff are working appropriately with their license requirements. 4)The DNS/Designee will audit random employee files to ensure accuracy. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 10/07/22	10/7/22

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F 880	Continued From page 18	F 880		
F 880 SS=D	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 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;	F 880		10/7/22

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F 880	Continued From page 19 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review the facility failed to ensure infection control procedures were followed during 1 random observation of wound care (#89). The finding were: 1. Observation on 8/29/22 at 3:13 PM showed RN #1 performed wound care on resident #89. The RN donned gloves, removed the dressing, and	F 880	DPOC will be followed as well as one listed below. F880 S/S=D: Infection Control and Prevention 1)RN #1 was made aware of surveyor observations at time of discovery and immediately verbally educated. No negative outcomes related to Resident	

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F 880	Continued From page 20 cleansed the wound. The RN then doffed her gloves and, without performing hand hygiene, donned cleaned gloves and applied the new dressing on the wound. Interview with RN #1 at that time confirmed she did not perform hand hygiene when going from a dirty procedure to a clean procedure. a. Interview with the Regional RN on 8/29/22 at 4:22 PM revealed it is the expectation of the facility that the nurse perform hand hygiene between dirty and clean dressing changes. b. Review of the policy titled "Handwashing/Hand Hygiene" provided by the ADON on 8/29/22 showed "...7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial and water for the following situations: ...g. Before handling clean or soiled dressings, gauze pads, etc.: ... i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.;"	F 880	#89. 2)Audit performed by AED and DNS, of entire building, randomly observing staff and units, to ensure compliance with hand hygiene. Any needed corrections were done at that time. 3)Staff were educated on expectations with hand hygiene. 4)DNS/Designee will audit hand hygiene ensure compliance. Audits will be weekly for 12 weeks and then monthly for three months. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results. 5)Date of Compliance: 10/07/22	