STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/23/23 to 1/26/23. 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: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set BIMS- Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 568		3/1/23

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

Electronically Signed | 02/14/2023

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F 568	Continued From page 1 (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and policy and procedure review, the facility failed to ensure resident fund account statements were provided at least quarterly. The census was 19. The findings were: 1. Interview with resident #3 on 1/24/23 at 2:49 PM revealed the resident had an account at the facility and had asked for statements; however, the facility had not provided any statements. 2. Interview with the DON on 1/26/23 at 9:12 AM revealed the facility performed a monthly tracking of funds and sent it out to family members; however, the copies did not indicate if or when it was sent to the resident or representative. Further interview revealed the facility was working to improve on the trust account process and she was not aware of any residents asking for statements. 3. Review of a policy titled "Resident Funds" last revised on 6/1/22 showed "...1. Each month, a statement of current resident fund balances and transactions from the last month will be made available to the resident and/or guardians..."	F 568	F568-Resident #3 provided with statement with account balance on 2/1/2023. All other residents and/or families/guardians received a hand delivered or mailed copy of statement with account balance by 2/7/2023. Each month Administrator or social services will mail or hand deliver a statement of account balances to either resident or their family/guardian. For hand delivered statements, a signature will be obtained on a copy of the statement. A copy of the statement will be retained in the resident chart. Administrator or designee will complete monthly audit to ensure statements are being delivered once per month. Any issues will be discussed by QAPI committee.	
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		3/1/23

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F 656	Continued From page 2	F 656		

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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F 656	Continued From page 3 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 10 sample residents (#8, #14) reviewed for care plans. The findings were: 1. Observation on 1/24/23 at 11:23 AM showed resident #8 was in his/her room. There was a sign located above his/her bed reminding the resident to wear oxygen. Review of physician orders dated October 2019 showed oxygen was ordered for 2 liters of flow at night. Review of the quarterly MDS assessment dated 12/20/22 showed the resident used oxygen. Review of the resident's care plan provided by the quality assurance manager on 1/25/23 showed a care plan for oxygen use was not developed. 2. Observation on 1/24/23 at 2:44 PM showed resident #14 had both legs wrapped with ACE wraps (wide elastic wrap). Interview with the resident at that time revealed that s/he had congestive heart failure and always had to use their wheelchair and have both legs wrapped every day. Review of the physician orders dated December 2022 showed an order for the resident to receive ACE wraps to bilateral legs daily. Further review showed an order dated 12/5/22 for Lasix (a diuretic medication) 40 milligrams (mg) every day. Review of the quarterly MDS assessment dated 12/06/22 showed diagnoses which included heart failure and essential hypertension. Review of the resident's care plan provided by the quality assurance manager on 1/25/23 showed a care plan for edema was not	F 656	F656 - Careplan was developed for Resident # 8 on 1/29/2023 to address oxygen use. Careplan was developed for resident #14 on 1/30/2023 to address heart failure, HTN, and edema. All resident careplans will be reviewed by 03/01/2023 to ensure all aspects of care are addressed appropriately in care plans. MDS coordinator or designee will complete monthly chart audit of at least 5 residents to ensure care plan remain updated and address all areas of care provided. Any issues identified will be discussed by QAPI committee.	

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F 656	Continued From page 4 developed. 3. Interview with the DON on 1/25/23 at 1:42 PM revealed that resident care items like oxygen use and edema should have been included in the care plans.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, and policy and procedure review, the facility failed to ensure necessary equipment was provided for 1 of 3 sample residents (#11) who were reviewed for positioning. The findings were: 1. Review of the quarterly MDS assessment dated 12/21/22 showed resident #11 had a BIMS	F 688	F688 - Wheelchair cushion for resident #11 was changed out on 1/26/2023 and resident□s feet were able to rest on the floor. Resident was provided with footrests in the event she is unable to reach the floor. All residents who use wheelchairs were assessed on 2/1/2023 to evaluate if feet touched floor and foot rests were	3/1/23

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F 688	Continued From page 5 score of 9 out of 15, which indicated moderate cognitive impairment, and diagnoses which included diabetes mellitus, non-Alzheimer's dementia, pain in left ankle and joints of left foot, pain in right ankle and joints of right foot, and age-related osteoporosis without current pathological fracture. The resident required total physical assistance of 2 or more people for transfers, extensive physical assistance of 1 person for locomotion on and off the unit, and had functional limitations in range of motion in his/her bilateral upper and bilateral lower extremities. Further review showed the resident was at risk for pressure ulcers. Review of the "decreased mobility d/t [due to] hip fx [fracture] repair" care plan provided by the quality assurance manager on 1/25/23 showed staff were to encourage the resident to wheel him/herself in the wheelchair as much as tolerated, assist with ADLs/transfers using a sit to stand mechanical lift and 2 person assist, and the resident was to work with restorative as tolerated. The following concerns were identified: a. Observation on 1/24/23 at 9:30 AM showed the resident was in his/her wheelchair with his/her feet dangling and not touching the ground. No footrests were used and the resident appeared to have bilateral lower extremity edema. b. Observation on 1/25/23 at 1:34 PM showed the resident was in his/her wheelchair with his/her feet not on the floor, wearing socks, and no footrests were in use. c. Interview with the DON on 1/26/23 at 9:04 AM revealed the resident had a hard time with transfers and dressing and was working with restorative for upper extremities. The DON revealed the resident had weakness and decreased mobility in his/her legs. Further interview revealed footrests should be used if the	F 688	provided for those who did not. All staff training for CNAs and nurses completed on 2/8/2023 to review foot rest and wheelchair positioning policy. DON, Administrator, or designee will perform weekly audit for 6 weeks to ensure foot rests are placed appropriately, then audits will occur monthly.	

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F 688	Continued From page 6 resident was unable to touch the floor. d. Observation on 1/26/23 at 9:23 AM showed the resident was seated in a recliner and a cushion was present in the resident's wheelchair. Interview with the DON at that time revealed the cushion in the chair was not the one previously used and may have been the reason the resident's feet did not touch the floor. Further interview confirmed if a resident was unable to touch the floor while seated in a wheelchair, footrests should be utilized. e. Review of the policy titled "Wheelchair Positioning" last revised on 6/1/22 showed " ...1. All residents will be positioned in wheelchair so that their feet can touch the floor. 2. If a resident has been repositioned and is still unable to touch the floor, staff will assist with putting foot rests on the wheelchair and appropriately placing feet on foot rests..."	F 688		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		3/1/23

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F 727	Continued From page 7 Based on staff interview and review of job duties, the facility failed to ensure a full time DON. The census was 19. The findings were: 1. Review of a "Job Duties Director of Nursing" and "Job Duties of Nursing Home Administrator" provided by the DON 1/26/23 at 8:47 AM showed the DON position averaged "about 32 hours per week" broken up by 10-15 hours for training and development of clinical staff, 5-10 hours for coordination of nursing/CNA schedules, 5-10 hours for MDS coordination/completion, 24 hours monthly (1-2 times per month as needed) for charge nurse duties, 5 hours for care plan development, and 1-5 hours for communication with families and residents. The total range of DON duties was 26-45 hours plus the time as the charge nurse. The administrator position averaged "about 32 hours per week" and required 1-5 hours for development and review of policies and procedures, 1-5 hours for the quality assurance programs, 1-5 hours for coordination of care with other departments, 1-5 hours for preparation and monitoring of the annual budget, 1-3 hours for coordination of care with outside services and providers, 1-3 hours for recruitment and hiring of staff, 1-3 hours of coordination of maintenance and environmental services, and 1-3 hours to oversee staffing and staffing budget. The total range of administrator duties was 8-32 hours plus daily assurance of compliance with federal and state regulations. The total range of hours for an average of 64 hours for the 2 positions was 34-77 hours per week. 2. Interview with the DON on 1/26/23 at 8:06 AM revealed in addition to the DON, she was the facility administrator, infection preventionist, MDS coordinator, performed staff education including	F 727	F0727 - Administration has approved division of DON and NH Administrator roles. Current DON will served as NH Administrator. HR and Administrator will develop specific job descriptions for each role and will fill the DON role with appropriately qualified RN. Job description will be completed and approved, and job listing will be posted by February 21, 2023. As of February 20,2023, a new DON has been hired and signed and agreed to the DON job description as developed by administration and HR. As of February 20, 2023, administrator has reviewed, agreed to, and signed job description as developed by administration and HR for Nursing Home Administrator.	

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F 727	Continued From page 8 monthly in-service training, and worked the floor at times. The DON revealed she thought she could fill both roles since the facility had less than 60 residents. Further interview revealed the DON and administrator positions were previously filled by 2 individuals.	F 727		
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 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	F 758		3/1/23

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F 758	Continued From page 9 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 staff interview, medical record review, and policy and procedure review, the facility failed to ensure as needed (PRN) orders for psychotropic medications were limited to 14 days for 1 of 5 sample residents (#17) and failed to ensure appropriate behavior monitoring and non-pharmacological interventions were in place for 2 of 5 sample residents (#3, #17) reviewed for unnecessary medications. The findings were: 1. Review of the annual MDS assessment dated 5/2/22 showed resident #3 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact, and diagnoses which included multiple sclerosis, bipolar disorder, opioid dependency, and chronic pain syndrome. Further review showed the resident received antipsychotic and antidepressant medications on 7 out 7 days during the look back period. Review of the physician's orders dated January 2023	F 758	F0758- Resident #3 and Resident #17 was reviewed by psychotropic committee on 1/31/2023. Appropriate target behaviors for each medication prescribed were identified and target behaviors with medications used were updated on behavior tracking. Appropriate resident specific nonpharmacological interventions were added to each resident□s care plan. Clonazepam prescribed to resident #17 was discontinued on 1/31/2023 due to ineffectiveness. DON reviewed all residents in psychotropic committee meeting on 1/31/2023. Appropriate target behaviors for each medication prescribed were identified and target behaviors with medications used were updated on behavior tracking. Appropriate resident specific nonpharmacological interventions	

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F 758	Continued From page 10 showed the resident received quetiapine fumarate (antipsychotic) 200 milligrams (mg) one tablet by mouth at bedtime, duloxetine HCL DR (antidepressant) 60 mg one capsule by mouth daily, and Restoril (hypnotic)15 mg one capsule by mouth at midnight. Further review showed behavior monitoring which included "...uncooperative/refusal of care, number of hours of sleeping, depressed/withdrawn, anxiety/anxious..." The following concerns were identified: a. Review of the "Psychotropic Drug Use" care plan provided by the quality assurance manager on 1/25/23 showed interventions which included "...Administer medications as ordered by physician. Observe [resident's name] for adverse side effects, document and report to physician. Monitor [resident's name] behavior-uncooperative/refusal of care, number of hours of sleep, depressed/withdrawn..." Further review showed no evidence medication specific target symptoms or non-pharmacological interventions were identified. b. Review of the medication administration record (MAR) and treatment administration record (TAR) for November 2022, December 2022, and January 2023 showed the facility had monitoring in place for depression/withdrawn, anxiety/anxious, uncooperative/refusal of care, number of hours of sleep; however, there was no evidence of resident specific target symptoms or non-pharmacological interventions identified for each medication. Further review showed the behavior monitoring did not identify medications used for the behaviors. 2. Reviewed of the admission MDS assessment dated 11/11/22 showed resident #17 was rarely/never understood, had short term and long	F 758	were added to each resident□s care plan. DON or designee will complete monthly chart audit to ensure appropriate behaviors are being tracked for medication usage, and appropriate nonpharm interventions are in place and addressed in careplan.	

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F 758	Continued From page 11	F 758		

term memory problems, and had diagnoses which included Alzheimer's disease, chronic pain syndrome, generalized anxiety disorder, fibromyalgia, chronic fatigue unspecified, and insomnia. Review of the January 2023 physician orders showed the resident received risperidone (antipsychotic) 1 mg tablet by mouth at bedtime and fluoxetine HCL (antidepressant) 40 mg capsule by mouth every day. In addition, the resident received clonazepam (benzodiazepam used to treat panic disorders, anxiety and seizures) 0.5 mg tablet by mouth 3 times per day as needed which was ordered on 11/11/22. The following concerns were identified:

a. Reviewed of the psychotropic medication care plan provided by the quality assurance manager on 1/26/23 showed interventions which included administering medications as prescribed by the physician, monitoring by the psychotropic committee at least quarterly, monitoring behaviors and documenting them every shift, notification of the provider immediately of any potential side effects or worsening behavior, and monitoring by the mental health specialist. Further review showed no evidence medication specific target symptoms or non-pharmacological interventions were identified.

b. Reviewed of the MAR and TAR for November 2022, December 2022, and January 2023 showed the facility had monitoring in place for wondering, and tearfulness/crying; however, there was no evidence of resident specific target symptoms or non-pharmacological interventions identified for each medication. Further review showed the behavior monitoring did not identify medications used for the behaviors and there was no stop date identified for the PRN clonazepam use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A051	A. BUILDING _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(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 758	Continued From page 12 4. Interview with the DON on 1/26/23 at 8:46 AM revealed the facility identified behavior monitoring in the monthly meeting; however, she confirmed the monitoring did not identify specific target symptoms for the use of each medication and the facility would be unable to determine the effectiveness or need for psychotropic medication use. Further interview confirmed the facility did not have a documented rationale for the as needed psychotropic medication being used more than 14 days. 5. Review of the policy titled " Psychotropic medications" last revised on 6/1/22 showed " ...4. For PRN orders for psychotropic drugs, the order is limited to 14 days, unless the provided provides documentation of medical necessity beyond 14 days with an updated duration for the order...6. Nursing staff will monitor and document behaviors that are being treated with these medications at least once per shift..."	F 758		