STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	1851 BIG HORN AVE SHERIDAN, WY 82801

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/5/23 to 2/8/23. The following common abbreviations are used throughout this document: BIMS- Brief interview for Mental Status DON- Director of Nursing MAR- Medication Administration Record MDS- Minimum Data Set mg- Milligrams PPE- Personal Protective Equipment RN- Registered Nurse TAR- Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		3/18/23

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

Electronically Signed | 03/06/2023

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 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record and policy and procedure review, and resident and staff interview, the facility failed to ensure residents were treated with dignity during 3 random observations which affected residents #13, #43, and #70. The findings were: 1. Review of the 12/28/22 quarterly MDS assessment showed resident #13 was admitted to the facility on 9/23/22 with a BIMS score of 11/15 (moderate cognitive impairment), a diagnosis of diabetes mellitus, and received insulin injections 7 days of the 7-day look-back period. The following concerns were identified:	F 550	F550 Dignity PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION	

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F 550	Continued From page 2 a. Observation on 2/5/23 at 5:25 PM showed the resident was seated in the Rock Creek dining room awaiting the evening meal. LPN #1 approached the resident at the table to perform a fingerstick to check his/her blood sugar level using a glucometer. After obtaining the blood sugar level, LPN #1 prepared an insulin pen and proceeded to inject the insulin into the resident's bare abdomen. The resident's abdomen was visible to the surveyor standing across the dining room. There were approximately 20 residents and staff in the dining room at that time. b. Interview with the resident on 2/6/23 at 10:16 AM revealed his/her blood sugar was always tested and insulin injected at the dining room table. c. Interview with LPN #1 on 2/5/23 at 5:28 PM revealed she routinely checked blood sugars and injected insulin in the dining room during the evening meal because, "It is nearly impossible to do it in their rooms because they are on the move so much." 2. Review of the 12/11/22 quarterly MDS assessment showed resident #43 was admitted to the facility on 9/11/20 with a BIMS score of 15/15 (cognitively intact), had a diagnosis of diabetes mellitus, and received insulin injections 7 days of the 7-day look-back period. The following concerns were identified: a. Observation on 2/5/23 at 5:33 PM showed the resident was seated in the Rock Creek dining room awaiting the evening meal. LPN #1 approached the resident at the table to perform a fingerstick to check his/her blood sugar level using a glucometer. After obtaining the blood sugar level, LPN #1 prepared an insulin pen and proceeded to inject the insulin into the resident's bare abdomen. The resident's abdomen was	F 550	THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Residents # 13 and #43 were asked what their preferences were regarding insulin administration. Care plans were updated to reflect resident preferences. Resident # 70 care plan has been updated to reflect care needs during showering to ensue dignity. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk to be affected by this alleged deficient practice. An audit was completed of all residents receiving insulin or blood sugar checks. Those residents receiving insulin/blood sugar checks were asked what their preferences are and those care plans were updated accordingly. III. MEASURES OR SYSTEMIC	

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F 550	Continued From page 3 visible to the surveyor standing across the dining room. There were approximately 20 residents and staff in the dining room at that time. 3. Review of the 12/18/22 admission MDS assessment showed resident #70 was admitted to the facility on 12/12/22 with diagnoses which included traumatic brain injury and morbid obesity. The resident required extensive assistance of two or more staff members for transfers and personal hygiene. The following concerns were identified: a. Observation on 2/6/23 at 10:51 AM showed the resident was in a shower chair in the hallway. The resident had on a green gown and a bath blanket was draped over the back side of the shower chair. The resident's ribs to buttocks were exposed on each side of his/her body as well as his/her buttocks on the bottom of the chair. b. Interview with occupational therapist #1 revealed she normally did not give showers and used the shower chair due to the resident's size. She further stated that she was unaware the resident had exposed skin. 4. Interview with the DON on 2/7/23 at 2:49 PM revealed the residents had requested blood sugar checks and insulin injections be given in the dining room. In addition, the DON stated it was the facility's expectation residents' skin not be exposed in common areas. Further interview with the DON on 2/8/23 at 10:02 AM confirmed there was no documentation which showed it was the residents' preference to have medications administered and blood sugar levels checked in the dining room. 5. Review of the "2001 MED-PASS, Inc. (revised February 2021) Dignity" policy showed "...5. e.	F 550	CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Starting 2/10/2023 all staff educated on resident dignity. All clinical staff and therapists were educated on resident rights and dignity in regard to showering, blood glucose checks, and insulin administration. DON/Designee will complete facility observation in 3 different areas weekly x 4 weeks, then monthly x 2 watching for any exposed areas going to and from showers, no blood sugar/insulin administration is not happening outside of resident’s preference. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. ¿ Date of Compliance: 3/18/2023	

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F 550	Continued From page 4 provided with a dignified dining experience...11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures."	F 550		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: F554 Based on observation, resident and staff interview, medical record review and policy review, the facility failed to ensure residents who self-administered medications were assessed and determined safe to do so by the interdisciplinary team for 3 random observations which affected residents #5, #56 and #278. The findings were: 1. Review of the 11/7/22 quarterly MDS assessment showed resident #5 was admitted to the facility on 3/2/22 with a diagnosis of cerebral palsy. Further review of the MDS assessment showed a cognitive assessment had not been completed. The following concerns were identified: a. Observation on 2/6/23 at 10:11 AM showed 9 medications were located on a blue-topped tray table located in the resident's room. There was no nursing staff in the vicinity of the resident's room. b. Review of the medical record showed no evidence a medication self-administration	F 554	F554 Self Administration Medications-Clinically Appropriate PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND	2/28/23

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F 554	Continued From page 5 assessment had been completed. 2. Review of the 2/6/23 resident admission record showed resident #278 was admitted to the facility on 2/3/23 with diagnoses which included unspecified severe protein-calorie malnutrition, essential hypertension, encounter for surgical after care following surgery on the digestive system and chronic obstructive pulmonary disease. Further review of the 2/6/23 Brief Interview for Mental Status tool showed a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The following concerns were identified: a. Review of the Nursing Admission Data Collection tool dated 2/5/23 at 4:34 AM showed resident #278 resident did not wish to self-administer medications. b. Observation on 2/7/23 at 8:55 AM showed resident #278 sitting in the Rock Creek dining room with 2 other residents. The resident was observed with 2 small cups of medications in pill and capsule form, and a small cup of liquid in front of him/her, and no nurse or medication aide was in the vicinity of the dining room. Interview with the resident at that time revealed s/he did not know what medications in front of him/her were or what they were for. The resident also stated s/he had not been evaluated for or requested to self-administer medications. The nurse was not present to observe administration of the medications. c. Further review of the medical records failed to show any assessment for the ability to safely self-administer medications had been performed. 3. Review of the 11/22/22 admission MDS assessment showed resident #56 was admitted to facility on 11/16/22 with diagnoses which	F 554	SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 5 has been interviewed for preferences, self-administration assessment in place with plan of care updated. Resident # 278 has been interviewed for preferences, self-administration assessment in place with plan of care updated. Resident # 56 has been interviewed for preferences, has self-administration assessment and plan of care in place. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any residents who self-administer medication are at risk due to deficient practice. If a resident requests to self-administer their meds, the nurse conducts a self-administration assessment. Said assessment then goes to the IDT team and, if deemed appropriate, a request is made to the provider. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT	

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F 554	Continued From page 6 included chronic respiratory failure with hypercapnia, muscle weakness, idiopathic epileptic syndromes with seizures and a history of falls, and a BIMS score of 15 out of 15 indicating the resident was cognitively intact. The following concerns were identified: a. Observation on 2/7/23 at 8:10 AM showed CNA #3 approached RN #3 and asked what the medications were in the medication cups left for resident #56 because the resident did not remember. The RN responded to the CNA "Folic acid and normal stuff". Further observation at the time showed there were medications left unattended on the resident's bedside table in 2 small cups, one small cup with red liquid and another with 5 medications in pill form. Interview with the resident at that time revealed the nurse was in a hurry so s/he left the medications. The resident also stated s/he had not been evaluated for or requested to self-administer medications. The nurse was not present to observe administration of the medications. b. Further review of the medical record failed to show any assessment for the ability to safely self-administer medications had been performed. 4. Interview with the CNA #3 on 2/7/23 at 8:50 AM confirmed the nurses usually left the medications for resident #56 at bedside and unattended. 5. Interview with RN #3 on 2/8/23 at 12:51 PM confirmed the medications were left at the dining room table for resident #278 and at the resident bedside table for resident #56 stating both residents were alert. Furthermore, the RN stated they were just normal medications and no narcotics were left unattended. 6. Interview with the DON on 2/8/23 at 12:50 PM	F 554	OCCUR AGAIN: The DON/Designee started and education in-service on 02/07/23 with nursing team (nurses and CMA's) on policy and the required process for self-administration. DON/Designee to complete weekly observations to make sure self-administration assessments are complete across all shifts/areas 3x weekly x 4 weeks on 10% of residents then monthly x 2 months. Audits will be to monitor that no meds are being left at bedside or in public area unless a self-administration assessment is complete with IDT approval and appropriately reflected in Care Plan. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 2/28/2023	

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F 554	Continued From page 7 confirmed the residents' medication self-administration assessments had not been completed. 7. Review of the facility policy "Self-Administration of Medications", last revised February 2021, showed "Residents may have the right to self-administer medications if the medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so."	F 554		
F 641 SS=D	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 and Resident Assessment Instrument (RAI) user's manual review, and staff interview, the facility failed to ensure the MDS assessment information was an accurate reflection of resident status for 3 of 21 sample residents (#1, #5, #15). The findings were: 1. Review of the 12/23/22 quarterly MDS assessment showed the cognitive and mood assessments had not been completed for resident #1. 2. Review of the 11/7/22 quarterly MDS assessment showed the cognitive and mood assessments had not been completed for resident #5. 3. Review of the 1/23/22 quarterly MDS	F 641	F641 Accuracy of assessments. PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF	3/1/23

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F 641	Continued From page 8 assessment showed the cognitive and mood assessments had not been completed for resident #15. 4. Interview with the MDS coordinator on 2/6/23 at 2:54 PM confirmed the cognitive and mood assessments had not been completed within the required 7-day look-back period. 5. Review of the RAI 3.0 user's manual, version 1.17.1 Section C (cognitive patterns) and Section D (mood) showed "...Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD)...".	F 641	PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 1, #5, and #15 have all had an updated BIMS and PHQ 9 completed. MDS was updated to ensure accurate reflection of resident's status if indicated. Plan of care updated as indicated to reflect residents' current status and needs. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk for inaccurate assessments due to deficient practice. All residents audited for BIMS and PHQ9 in the last quarter, any residents identified with no assessments were completed and care plans reviewed and updated. The BIMS and PHQ9 will be completed within the 7 day look back period on their next scheduled MDS. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT	

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F 641	Continued From page 9	F 641	OCCUR AGAIN Each resident will have a BIMS and PHQ (completed within the 7 day look back period on their next scheduled MDS. NHA/designee completed an education in-service on 2/10/2023 with IDT team and MDS coordinator in accordance with the RAI manual on the timeliness and accuracy of the BIMS and PHQ9. The MDS Coordinator will schedule MDS assessments and notify IDT. The appropriate party will complete the PHQ9/BIMS assessment per the MDS schedule. The MDS/designee will audit 10% of MDS assessments weekly for 4 weeks, then monthly for 2 additional months to ensure that BIMS/PHQ9 were completed during the lookback period and coded in MDS. Any concerns will be corrected immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The MDS/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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The MDS/Designee will be responsible to	

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F 641	Continued From page 10	F 641	follow up on any recommendations made by the QAPI Committee. Date of Compliance: 03/01/2023	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		3/1/23

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	535026	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	1851 BIG HORN AVE SHERIDAN, WY 82801

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F 655	Continued From page 11 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to develop and implement baseline care plans for 5 out of 5 (#64, #72, #74, #277 and #278) residents resulting in failure to provide a continuity of care, effective and person centered care. 1. Review of the 12/22/22, admission MDS assessment showed resident #64 was admitted on 12/16/22 with a BIMS score of 15/15 which indicated the resident was cognitively intact, and had diagnoses which included non-traumatic chronic subdural hemorrhage, need for assistance with personal care, repeated falls, diabetes mellitus, moderate protein-calorie malnutrition, and stroke. The following concerns were identified: a. Review of baseline care plan (effective 12/18/22) interventions failed to identify person-centered care for fall management, diabetic management, ADL function, and food and nutrition management. Interview with the resident on 2/5/23 at 4:30 PM at that time revealed he was diabetic, had recent falls and poor appetite.	F 655	F655 Baseline Care Plans PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.	

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F 655	Continued From page 12 2. Review of the 12/9/22 admission MDS assessment for resident #72 showed the resident was admitted on 12/5/22, had a BIMS score of 7/15 which indicated the resident had severely impaired cognition, and diagnosis which included fractures and other multiple trauma, vision loss, fracture related to a fall, history of falling, and mixed incontinence. Further review showed a pain intensity of 10/10 indicating the worst pain possible and malnutrition. The following concerns were identified: a. Review of the medical record failed to show evidence a baseline care plan was initiated within 48 hours of the resident's admission. 3. Review of medical record Review of medical record effective 1/10/23 admission MDS assessment showed the resident #74 was admitted on 1/4/23 with a BIMS score of 9/15 which indicated the resident had moderate cognitive impairment with diagnoses which included diabetes mellitus, dementia, other fracture, abnormal weight loss, and need for personal assistance. The following concerns were identified: a. Review of baseline care plan effective 1/5/23 failed to identify person-centered care interventions for fall management, pain management, ADL function, and food and nutrition management. 4. Review of the medical record dated 1/31/23 admission MDS assessment for resident #277 showed the resident was admitted on 1/27/23 with a BIMS score of 12/15 which indicated the resident had moderately impaired cognition and diagnoses which included urinary tract infection, sepsis due to pseudomonas, bipolar disorder,	F 655	¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 64 has had care plan updated to reflect fall management, Diabetic care needs, ADL function, and food and nutrition needs. Resident # 72 has had plan of care updated to include Fall and Pain management, ADL function, and Food and Nutrition management. Resident # 74 has had plan of care updated to include fall and pain management. Resident # 277 has had comprehensive pare plan updated. Resident # 278 has had plan of care updated to include Fall and pain management, ADL function, bowel function and Food and nutrition management. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All new admissions are at risk due to deficient practice. New admissions for the past 30 days have been reviewed by the IDT to ensure the baseline care plans meet their current needs and monitor medical conditions. Residents that were found to have not received a copy of their plan of care were provided with one by 3/1/2023.	

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F 655	Continued From page 13 dependence on supplemental oxygen, unsteadiness on feet, need for assistance with personal cares. The following concerns were identified: a. Review of the medical record failed to show evidence a baseline care plan was initiated within 48 hours of admission. 5. Review of the medical record dated 2/9/23 for the admission MDS assessment for resident #278 showed the resident was admitted to the facility on 2/3/23, had a BIMS score of 15/15 which indicated the resident was cognitively intact, a pain evaluation completed on 2/5/23 indicating the resident had a score of 8 of very severe pain and diagnoses which included diabetes mellitus, hypertension, anemia, arthritis, gastrostomy status and malnutrition. The following concerns were identified: a. Review of the resident's baseline care plan printed on 2/6/23 failed to show person-centered care interventions for fall management, pain management, ADL function, bowel function and food and nutrition needs. Interview with the resident on 2/6/23 at 1:00 PM revealed the resident had arthritic pain, recent surgeries and his/her blood sugar was too high on 2/5/23. 6. Interview with ADON on 2/7/23 at 4:29 PM confirmed the facility failed to develop baseline care plans that included instructions needed to provide effective and person-centered care to newly admitted residents.	F 655	III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN Starting 2/10/23 DON/designee initiated an education with IDT team and floor nurses on what is required with a baseline care plan as well as expectations of person-centered care needs. The DON and/or designee will complete an audit within 24 hours of admission x4 weeks, then monthly for 2 additional months. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/01/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		3/1/23

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F 656	Continued From page 14 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 15 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 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 2 of 21 sample residents (#34, #47) had resident-specific care plans that reflected individual needs in all required areas. The findings were: 1. Review of the 12/31/22 quarterly MDS assessment showed resident #34 was admitted to the facility on 11/12/20 with diagnoses which included Parkinson's disease, schizophrenia, chronic obstructive pulmonary disease, and chronic atrial fibrillation. The review showed the resident required extensive assistance of 1 staff for personal hygiene and toileting. Review of the 1/16/23 Braden Scale assessment showed the resident scored a 15, which showed the resident was at risk for developing a pressure ulcer. Review of the 1/1/23 weekly skin assessment showed the resident had no pressure ulcers or skin issues at that time. Review of the 1/5/23 weekly skin assessment showed the resident had a right heel pressure ulcer. Interview with the DON on 2/7/23 at 3:44 PM confirmed the facility identified a pressure ulcer on the resident's right heel on 1/2/23. Review of the care plan showed the resident had a plan to address pressure ulcers on 12/8/18. The following concerns were identified: a. Review of the entire medical record showed the facility failed to perform a Braden Scale assessment for pressure ulcer risk on the	F 656	F656 Develop/Implement Comprehensive Care Plan PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	

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F 656	Continued From page 16 resident prior to 1/16/23 (14 days after identification of a right heel pressure ulcer). b. Review of the care plan showed a 12/8/18 focus for actual impairments to skin integrity, which was revised 1/2/23 to include pressure injury to the resident's right heel. Further review showed the plan was revised on 1/29/23 (27 days after identification of the right heel pressure ulcer) to include an off-loading boot to the right foot to prevent further pressure injury, and continued review showed no plan related to repositioning or off loading until that time. Review of the progress notes showed the resident's right foot was being utilized on 1/6/23. c. Interview with the DON on 2/7/23 at 3:44 PM confirmed the facility failed to perform a Braden Scale assessment for pressure ulcer risk prior to the resident developing a pressure ulcer. She further confirmed the facility failed to initiate timely care plan interventions to address floating or off-loading the resident's heels until 1/29/23 (27 days after the identification of the pressure ulcer), and then the plan only addressed the right heel. 2. Review of the 12/13/22 quarterly MDS assessment showed resident #47 was admitted to the facility on 5/26/20 with diagnoses which included diabetes mellitus II, anxiety disorder, and chronic obstructive pulmonary disease. The review showed the resident required the extensive assistance of 1 person with personal hygiene. Review of physician orders showed an 8/25/22 order for Seroquel (anti-psychotic) 100 mg by mouth daily. Review of the January and February 2023 MARs showed the resident continued to receive Seroquel as ordered. Review of the care plan showed the resident had a 12/24/22 plan for anti-psychotic use regarding	F 656	Resident # 34 has care plan updates completed as indicated to address pressure ulcer needs. Updated Braden, and updated interventions. Resident # 47 care plan has been personalized to address target behaviors and personalized interventions to prevent/redirect the behavior. Process has been established on the frequency of behavior monitoring, who assess the behavior and who implements the interventions. Process also defines what to do if interventions are not successful. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents who require behavior monitoring or who have pressure ulcers are at risk due to deficient practice. By 3/1/2023 the facility completed an audit of residents with pressure ulcers and residents with behaviors and residents' care plan were updated as needed. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed on 2/10/2023 with IDT and all staff on behavior monitoring and management process by the DON/designee. Education completed with Nurses on care plan updates and assessments when a concern is identified	

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F 656	Continued From page 17 behavior management. The following concerns were identified: a. Review of the care plan showed the 12/24/22 plan for anti-psychotic use regarding behavior management included the following interventions regarding "target behaviors": 1=anxiety, 2=agitation, 3=anger, 4=refusing assistance with cares. The interventions failed to individualize the behaviors, identify which staff members were required to assess those behaviors, how often the assessments were to be documented, and what was to be implemented if those behaviors were present. b. Interview with the DON on 2/8/23 at 10:11 AM confirmed the interventions on the care plan for the use of an anti-psychotic medication were non-specific, the plan was not individualized to identify target behaviors, how often they should be documented and by which staff members, and what staff were to do if the behaviors were present.	F 656	requiring interventions. The DON and/or designee will complete an audit 5 x per weekly during morning clinical meeting ensuring significant change and or alerts are communicated with the provider/POA as indicated and are documented in the medical record. All resident skin concerns including pressure ulcers will be monitored weekly during weekly wound rounds and weekly risk meetings. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. ¿ Date of Compliance: 3/01/2023	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		2/13/23

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F 684	Continued From page 18 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interview, and policy and procedure review, the facility failed to ensure 1 of 5 sample residents (#1) reviewed for bowel management received the appropriate care and treatment to address constipation. This failure resulted in hospitalization and actual harm to the resident. The findings were: 1. Review of the 9/20/22 quarterly MDS assessment showed resident #1 was admitted to the facility on 11/2/15 with a diagnosis of cerebral palsy and had a BIMS score of 15/15 (cognitively intact). Further review showed the resident was always continent of bowel and required the extensive assistance of 2 or more staff members for toilet use and transfers. Review of the fluid maintenance care plan, last revised on 8/2/22, showed the resident was at risk for fluid maintenance issues related to impaired mobility, poor bowel regulation, history of urinary retention, and a history of constipation. The interventions included "monitor bowel pattern to ensure [the resident] is having a regular bowel movement frequently that are soft and formed." Review of the medication administration record (MAR) showed the resident was prescribed psyllium husk powder (soluble fiber) every other day, for "Bulk and regulate bowel movements" with an	F 684	F684 Quality of Care PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	

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F 684	Continued From page 19 order date of 5/19/21; bisacodyl (laxative) suppository, as needed, for 4 days with no bowel movement with an order date of 6/26/19; docusate sodium (laxative with stool-softening activity) capsule, as needed, every 12 hours for constipation with an order date of 1/6/20; an enema, as needed, for 5 days with no bowel movement with an order date of 6/26/19; Milk of Magnesia (laxative), as needed, for 3 days with no bowel movement with a start date of 6/26/19; MiraLax (laxative) powder, as needed, for constipation with an order date of 9/23/20; and Senna (laxative) tablet to be given every 24 hours, as needed, for constipation The following concerns were identified: a. Interview with the resident on 2/5/23 at 3:42 PM revealed s/he had been hospitalized for a bowel obstruction. The resident stated s/he attempted to "hold in" his/her bowel movements; however, was told by the physician that was not a "good idea". An additional interview with the resident on 2/8/23 at 10:41 AM revealed s/he tried to "hold in" his/her bowel movements because the staff were slow to assist him/her and s/he did not want to be embarrassed. b. Review of the October 2022 bowel elimination documentation showed the resident had bowel movements (formed/normal; small in size) on 10/1/22 and on 10/6/22 (constipated/hard; large in size). The resident was given a bisacodyl suppository on 10/5/22 (day 4) which was noted as being semi-effective. Review of the October 2022 MAR showed no documentation the absence of a bowel movement had been addressed before day 4. c. Review of the October 2022 bowel elimination documentation showed the resident had bowel movements (constipated/hard; small in size) on 10/6/22 and on 10/11/22 (formed/normal;	F 684	Resident's #1 care plan reviewed to ensure it follows policy. Orders were verified to ensure Bowel Protocol was clear with proper regimen of interventions. Care plan reviewed to ensure fluid maintenance focus was clear. Gastro-Intestinal focus was updated for the identified resident. Resident's MAR was reviewed for the last 60 days and found no need for the PRN bowel protocol. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents who experience constipation are at risk due to deficient practice. Facility wide review of Bowel status completed on 02/07/2023 to ensure any resident with no documented BM within three (3) days have received the correct interventions and documentation per facility protocol. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The DON/designee initiated and completed an education in-service with all nursing staff by 2/13/2023 on bowel protocol. The DON and/or designee will complete an audit daily Mon-Fri weekly for 4 weeks, then monthly for 2 additional months during morning clinical meeting	

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F 684	Continued From page 20 large in size). Review of the October 2022 MAR showed no documentation the absence of a bowel movement for 4 days had been addressed. d. Review of the October 2022 bowel elimination documentation showed the resident's next bowel movement, from the 10/11/22 date, occurred on 10/19/22 (constipated: large in size). Review of a 10/16/22 at 7:59 AM nurse's progress note showed "Resident reports no BM [bowel movement] in 4 days previous to this morning. Yesterday resident refused Metmucil stating [s/he] "will go" No BM yesterday. Resident refuses Miralax this morning. No PRN [as needed] order for the fiber [s/he] did not think [s/he] needed yesterday. MAC [certified medication aide] and this writer went over resident's PRN orders. [The resident] agreed to try a Senna (laxative), agreed that if there is no BM by this afternoon/before dinner [s/he] will take some warm prune juice with Miralax added. However, review of the October 2022 MAR showed no documentation Senna or any other PRN medication for constipation was administered at any time between 10/16/22 and 10/27/22. e. Review of the October 2022 bowel elimination documentation showed the resident had a bowel movement on 10/20/22 (constipated/hard; large in size). No other bowel movements were documented after 10/20/22. Review of a nurse progress note dated 10/27/22 and timed 5 AM showed "Resident not feeling well. Emesis frequently. Abdomen sore and enlarged. Resident given suppository with no results...Bowel sounds diminished." Review of the October 2022 MAR showed no documentation the absence of bowel movement for 6 days had been addressed, and no documentation a suppository waa administered. f. Review of the medical record showed the	F 684	ensuring BM's are documented and correct interventions and notifications are in place. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. ¿ Date of Compliance: 2/13/2023	

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	535026	A. BUILDING _____ B. WING _____	02/08/2023

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F 684	Continued From page 21 resident was transferred to the hospital on 10/27/23. g. Review of the resident's "Patient Discharge Instructions" from the hospital, dated 10/30/22, showed the resident had diagnoses which included small bowel obstruction and constipation. 2. Interview with the DON on 2/7/23 at 2:41 PM revealed it was the facility's expectation the bowel protocol be followed. Further, the DON confirmed there was no further documentation and the resident's physician had not been notified. 3. Review of the Bowel Movement Protocol, revised November 2020, showed "Day 3 of No Bowel Movement Milk of Magnesia Suspension 1200 MG/15ML-administer 30 Ml Q [every] 24 hours PRN [as needed] no bowel movement in three (3 days); Day 4 of No Bowel Movement Bisacodyl Laxative Suppository 10 MG-Administer One (1) Suppository rectally Q 24 hours PRN no Bowel Movement in four (4) days; Day 5 of No Bowel Movement Enema Ready-To-Use Rectal Enema 7-19 GM/118 ML-Administer one (1) enema @ 24 hour PRN no Bowel Movement in five (5) days. If previous interventions are not effective and resident has not had an adequately sized Bowel Movement contact primary care provider for further orders and advisement.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		3/1/23

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F 689	Continued From page 22 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to assess 1 of 2 sample residents (#277) who smoked for safety and level of supervision required. The findings were: 1. Review of the 1/31/23 admission MDS assessment showed resident #277 was admitted on 1/27/23 with diagnoses which included sepsis, chronic obstructive pulmonary disease, essential hypertension, need for assistance with personal care and dependence on supplemental oxygen. The resident had a BIMS score of 12 out of 15 indicating the resident was moderately impaired. Review of the 1/27/23 Nursing Admission Data Collection tool showed the resident was alert, used oxygen and did not use tobacco products. The following concerns were identified: a. Observation on 2/6/23 at 3:48 PM showed the resident went outside to smoke, escorted by the ADON after removing the resident's portable oxygen. b. Interview on 2/7/23 at 1:58 PM with the resident showed s/he had been smoking 3 times a day since s/he was admitted, and no one had interviewed her/him about her/his smoking habits. c. Interview on 2/7/23 at 2:17 PM with CNA #4 revealed the resident had been smoking at the facility since admission on 1/27/23. d. Interview on 2/7/23 at 4:29 PM with the ADON confirmed the facility failed to assess the resident for safety prior to smoking. e. Review of the medical record showed the	F 689	F689 Accidents and Hazards PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 277 has had a smoking assessment completed and plan of care updated.	

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F 689	Continued From page 23 facility failed to initiate a safe smoking evaluation prior to the surveyor's observation on 2/6/23. Further review failed to show safe smoking in the resident's care plan or any noted physician's consultation. f. Review of the 1/27/23 discharge note showed "[S/He] does have a long history of smoking, currently 1.5 pack/day prior to admission." 2. Review of "Smoking Policy- Residents" last revised July 2017 showed "1. Prior to, and upon admission, residents shall be informed of the facility smoking policy," ..... "6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include ...d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation)."	F 689	II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident who smokes is at risk due to deficient practice. By 3/1/2023 an audit of all smokers was completed to ensure assessments were up to date and plan of care reflected smoking status/precautions. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed by the DON/designee with IDT team and Nursing staff on smoking policy on 2/9/2023. The SSD/or designee will complete an audit of all new admissions ensuring if they are a smoker and if a smoking assessment is needed and completed and plan of care is updated. Audit will be ongoing weekly for 4 weeks, then monthly for 2 additional months. Any findings will corrected immediately. Smoking assessments will be reviewed on admission, quarterly, and with any significant changes to ensure all assessments are up to date for each smoker in the facility. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE	

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F 689	Continued From page 24	F 689	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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. ¿Date of Compliance: 3/1/2023	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		3/1/23

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F 732	Continued From page 25 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of the nursing staff postings and staff interview the facility failed to ensure the daily staff information was in a prominent location; readily accessible to residents and visitors. Additionally the facility failed to include the actual hours worked on the on the daily staff postings. The census was 77. The findings were: 1. Observation at 6:30 PM showed the daily nursing staff posting was hanging by the employee time clock. Interview with the administrator at that time confirmed the nursing staff posting was usually hanging at the employee time clock which was not an area that was easily accessible to residents or visitors. 2. Review of the Daily Staff Posting from 1/1/23 to	F 732	F732 Posted Nurse Staff Information PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND	

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F 732	Continued From page 26 1/31/23 failed to show the actual hours worked by the registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides responsible for resident care per shift. 3. Interview on 02/08/23 at 09:08 AM with the scheduler revealed she was not aware of the nurse staff information posting requirements. She confirmed the actual hours worked had not been posted for the resident care staff.	F 732	PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were affected. The appropriate posting of nurse hours was posted. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: No residents were identified at being at risk. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education provided to staffer by the DON/designee on 2/28/2023 on correct way to update reflecting actual hours worked. Posting now located in highly visible area for residents and visitors. DON/designee will complete an audit weekly for 4 weeks, then monthly for 2 months to ensure actual hours worked are reflected accurately.	

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F 732	Continued From page 27	F 732	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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/1/2023	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §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.	F 756		3/1/23

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F 756	Continued From page 28 (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: Based on medical record review, staff interview, and policy review, the facility failed to ensure a monthly pharmacy drug regimen review was completed for 1 of 6 sample residents (#47) reviewed for medication irregularities. The findings were: Review of the 12/13/22 quarterly MDS assessment showed resident #47 was admitted to the facility on 5/26/20 with diagnoses which included diabetes mellitus II, anxiety disorder, and chronic obstructive pulmonary disease. The review showed the resident had a BIMS score of 7/15, indicating moderate cognitive impairment. The following issues were identified:	F 756	F756 Drug Regimen Review PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN	

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F 756	Continued From page 29 a. Review of the physician orders showed the resident had an 8/25/22 order for Seroquel (anti-psychotic) 100 mg by mouth daily for anxiety due to a known physiological condition, and a clinical explanation provided on 2/7/23 by the pharmacist showed anxiety as a diagnosis was acceptable for the use of Seroquel related to the resident also taking sertraline (anti-depressant). b. Review of the 2/7/23 Medication Regimen Review, the only Medication Regimen Review provided, showed the pharmacist marked the following, "A reduction would likely worsen or destabilize the resident's condition." Further review showed the physician had the following 3 options as a response: Agree, Disagree, or Other. The physician initialed below those choices and dated the recommendation for 2/7/23. However, the physician failed to select a choice, leaving the choice section blank. The Medication Review also failed to identify that no specific behaviors were identified and monitored. Review of the entire medical record showed pharmacy drug regimen reviews were not in the medical record. c. Interview with the DON on 2/8/23 at 9:52 AM showed there was a breakdown in the system regarding drug regimen reviews and a communication breakdown with the medical director. The facility failed to follow-up with the director and the facility was unsure where actual "papers" went. The facility had initiated a performance improvement project related to the failure. Review of the facility policy titled, "Medication Regimen Reviews, last revised May 2019. The following statement was documented under "Policy Statement"; "The consultant pharmacist reviews the medication regimen of each resident at least monthly." The following was documented	F 756	SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 47 has target behavior tracking in place and updated and completed pharmacy drug regimen review. Plan of care updated accordingly. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to deficient practice. DON/designee reviewed and completed current Resident’s pharmacy recommendations that were received in last 30 days. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed by the NHA/designee with the DON and the medical provider beginning 2/10/2023 on	

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F 756	Continued From page 30 under "Policy Interpretation and Implementation," ...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	Drug Regimen Review (DRR) process and policy. All completed DRR will be completed as indicated by the provider, signed and placed in pharmacy binder. DON/Designee will complete a comprehensive review of all pharmacy drug reviews monthly for 3 months. Audit will be ongoing for a period determined by the QAPI committee for continued compliance. ¿¿ 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/1/2023 ¿	
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	F 758		3/1/23

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F 758	Continued From page 31	F 758		

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 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.

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	535026	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	1851 BIG HORN AVE SHERIDAN, WY 82801

(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 32 §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, facility policy review, and staff interview, the facility failed to ensure residents were free from unnecessary psychotropic medications for 2 of 5 residents (#31, #47) reviewed. The findings were: 1. Review of the 12/31/22 quarterly MDS assessment for resident #31 showed diagnoses which included Parkinson's disease, neurocognitive disorder with Lewy bodies, dementia, and traumatic brain injury. Further review showed the resident received an antipsychotic on a daily basis. Review of the physician orders showed Olanzapine (antipsychotic) 5 milligrams (mg) was started on 9/21/21. The following concerns were identified: a.. Review of the 12/31/22 quarterly MDS assessment showed a gradual dose reduction (GDR) had not been attempted, nor was there physician documentation that a GDR was clinically contraindicated. b. Interview on 2/8/22 at 10:12 AM with the DON confirmed a GDR had not been attempted. c. Review of the Medication Regimen Review dated 2/7/23 showed a physician statement directing the facility continue the olanzapine at the current dose; however, a rationale for not implementing a GDR was not provided. 2. Review of the 12/13/22 quarterly MDS assessment showed resident #47 was admitted to the facility on 5/26/20 with diagnoses which	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN use PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 31 has a new drug regimen	

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F 758	Continued From page 33 included diabetes mellitus II, anxiety disorder, and chronic obstructive pulmonary disease. The review showed the resident had a BIMS score of 7/15, indicating moderate cognitive impairment. The following issues were identified: a. Review of the physician orders showed the resident had an 8/25/22 order for Seroquel (anti-psychotic) 100 mg by mouth daily for anxiety due to a known physiological condition, and a clinical explanation provided on 2/7/23 by the pharmacist showed anxiety as a diagnosis was acceptable for the use of Seroquel related to the resident also taking sertraline (anti-depressant). However; the review showed specific targeted behaviors were not documented. b. Review of the MARs for January and February 2023 showed the resident received Seroquel as ordered. The review of the MARs and TARs for January and February 2023 showed no specific targeted behaviors as being monitored related to the administration of Seroquel. c. Review of the nursing progress notes from 1/8/23 through 2/7/23 showed no behavioral symptoms were documented. d. Review of the care plan showed the 12/24/22 plan for anti-psychotic use regarding behavior management showed the following interventions regarding "target behaviors": 1=anxiety, 2.=agitation, 3.=anger, 4=refusing assistance with cares. The interventions failed to individualize the behaviors, identify which staff members were required to assess those behaviors, how often the assessments were to be documented, and what was to be implemented if those behaviors were present. e. Interview with the DON on 2/8/23 at 10:11 AM confirmed specific behaviors were not being monitored related to the use of Seroquel. Interview with the DON on 2/8/23 at 9:52 AM	F 758	review with GDR recommendations and rational in place with plan of care updated. Resident # 47 has specific targeted behavior tracking in place r/t psychotropic medication. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Resident who receives psychotropic medications are at risk due to deficient practice. An audit was completed by the DON/designee to identify any additional residents who receive psychotropic medications, and their care plans updated as needed. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed with IDT team and all nursing staff by the NHA/designee on process that has been established for the frequency of behavior monitoring, who assesses the behavior, and who implements the interventions. Process also defines what to do if interventions are not successful. SSD/Designee will review all psychotropic medications at the start of medication, any dose change, and at least quarterly through the order listing report and MDS calendar. Audit will be completed daily Mon-Fri for 4 weeks, then monthly for 2	

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F 758	Continued From page 34 revealed there was a breakdown in the system regarding drug regimen reviews and a communication breakdown with the medical director. The facility failed to follow-up with the director and the facility was unsure where actual "papers" went. The facility had initiated a performance improvement project related to the failure. Review of the facility policy titled, "Medication Regimen Reviews, last revised May 2019. The following was documented under "Policy Interpretation and Implementation," ...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..."	F 758	months during clinical meeting. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/1/2023	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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	F 761		2/15/23

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F 761	Continued From page 35 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 review, the facility failed to secure medications when no authorized staff were present for 1 of 4 storage areas (Rock Creek/ East Hall) observed. The findings were: 1. Continuous observation on 2/7/23 from 7:40 AM to 7:45 AM of Rock Creek hall and medication cart showed the medication cart was unattended and unlocked (showing a red dot indicating the push lock was unlatched). RN #2 exited resident room 108 at 7:45 AM, and returned to the medication cart, and locked. Interview with the RN at that time revealed she was aware the medication cart should be locked when left unattended. 2. Review of the "Storage of Medication" policy, last revised November 2020, showed "Unlocked medication carts are not to be left unattended."	F 761	F761 Label/Store drugs and Biologicals PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.	

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F 761	Continued From page 36	F 761	¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility had secured the medications in the identified medication cart. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to deficient practice. All medication carts have been audited by the DON/designee to ensure that medication carts are properly locked and are not left unattended. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed with all Nurses by the DON/designee on drug storage and ensuring carts are locked when not in direct line of sight. DON/Designee will complete weekly audits across all shifts weekly for 4 weeks, then monthly for 2 additional months. Any concerns will be addressed immediately. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE	

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F 761	Continued From page 37	F 761	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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. ¿Date of Compliance: 2/15/2023	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		3/1/23

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F 812	Continued From page 38 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the 2017 Food Code, and manufacturer's recommendations for use, the facility failed to ensure a sanitary environment in 1 of 1 food preparation areas, failed to ensure hair restraints were used during 2 random observations, and failed to ensure food was stored under safe conditions for 1 of 1 refrigerator/freezer observed outside of the kitchen area (Rock Creek Nurses Station). The findings were: 1. Regarding staff hygiene: a. Observation on 2/6/2022 at 8:45 AM in the Rock Creek dining room showed dietary aide #1 with a beard, blue mask and no beard hair net while serving the breakfast meal. b. Observation on 2/7/23 at 1:41 PM in the kitchen area, primarily in the dishwashing machine area, showed dietary aide #1 with a surgical mask on, and his beard was clearly observed hanging behind and below the mask without a cover. The dietary aide was handling clean dishes at that time. c. Interview on 2/7/23 at 2:05 PM with dietary aide #1 confirmed he routinely served breakfast at any one of the service areas. It was observed at that time he still had a beard showing without a cover. According to Food Code 2017, U.S. Public Health Service: 2-402.11 "(A) ...FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS,	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Completed deep clean of kitchen has been completed including pipes. All items not dated were disposed of. a. All equipment and kitchen surface areas has been added to a deep clean	

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F 812	Continued From page 39 and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 2. Regarding unsanitary items in the kitchen prep area: a. Observation on 2/7/23 at 5:55 PM showed a Hessaire swamp cooler at the corner of the food preparation area that was visibly dark and soiled with debris; in particular, the filters on the right and left side were visibly darkened and soiled and were not clean. Opposite the Hessaire swamp cooler by the toaster area was an upright fan that was darkened and soiled with debris. Observation above the preparation area were 3 pipes across the kitchen and a half pipe for the sprinkler system that was visibly dirty and soiled. b. Interview with dietary aide #2 on 2/7/23 at 4:39 PM revealed the swamp cooler was used to cool off the kitchen when the kitchen became to warm to work. According to Food Code 2017, U.S. Public Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. According to the manufacturer's manual titled, "Hessaire 1300 CFM Mobile Evaporative Cooler MC18 User Manual, dated November 6, 2021, documented under "Operation Tips"...Clean media pads and tank frequently." Under "Cleaning Cooler & Rigid Media Pads:" ws the following, "The removeable panel(s) & pads can be gently sprayed off to remove build up. A soft bristle brush can also be used." 3. Regarding the tile floor in the kitchen and	F 812	schedule. b. Filters have been cleaned to manufacture recommendations and placed on schedule. c. All dietary staff have hair and beard nets in place. d. Broken tiles have been repaired, fridge pantry area tiles, dishwasher area tiles. e. Compartment sink drain has been repaired. f. Pipes have been cleaned. Dishwashing area has been deep cleaned. g. Temp log on freezer has tracking in place. h. All supplements have thaw and use by dates as indicated. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk due to deficient practice. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education completed with all dietary staff by the NHA/designee on: Deep cleaning schedule, Hair restraints, how to clean filters, temp log tracking on all fridge and freezer that contain resident items, supplement thaw on and use by dates. How to identify and report non cleanable surfaces. Dietary manager/Designee will complete weekly audits for 4 weeks, then monthly	

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F 812	Continued From page 40 dishwashing machine area: a. Observation on 2/7/23 at 5:27 PM showed floor tiles were 1 foot by 1 foot in size, and 2 tiles to the left of the 3 compartment sink at the drain area were damaged, which collected darkened dirt and presented an uncleanable surface. Three floor tiles were damaged in front of the 2 door fridge in the panty area, which were darkened and presented an uncleanable surface. Damaged and mostly missing tiles under the dishwashing machine presented a darkened dirty area with an uncleanable surface. 4. Regarding storage of food: a. Observation on 2/5/23 at 4:20 PM of the Whirlpool refrigerator/freezer located behind the Rock Creek nurses' station showed a temperature log for the refrigerator; however, there was no documentation the temperature of the freezer was monitored. The freezer contained ice cream, popsicles, and candy bars. b. Observation on 2/5/23 at 4:20 PM of the Whirlpool refrigerator located behind the Rock Creek nurses' station showed 3 vanilla and 2 chocolate Mighty Shakes cartons. None of the cartons were marked with a thawed-on or use-by date. Review of the Mighty Shake carton showed "Store frozen. Thaw under refrigeration. After thawing keep refrigerated and use within 14 days after thawing." b. Interview on 2/5/23 at 4:24 PM with CNA #1 confirmed the food in the refrigerator/freezer was for resident use. According to Food Code 2017, U.S. Public Health Service 4-204.112: "(B) Except as specified in (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be	F 812	for 2 more months to ensure all equipment and walls/pipes/filters are deep cleaned per schedule. Dietary manager/Designee will audit fridge/freezer temp logs weekly for 4 weeks, then monthly for 2 additional months. Dietary manager/designee will monitor supplement thaw-on use by dates weekly for 4 weeks, then monthly for 2 additional months. Dietary manager/designee will complete weekly audit of kitchen to ensure all areas are cleanable surfaces and there are no broken tiles weekly for 4 weeks, then monthly for 2 additional months. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 03/01/2023	

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F 812	Continued From page 41 designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display." 5. Interview with the certified dietary manager (CDM) on 2/8/23 at 9:10 AM confirmed the Hessaire swamp cooler was dirty and not on a cleaning schedule. She further confirmed the upright fan and sprinkler system was not clean and not on a cleaning schedule. She stated her expectation was for any staff with a beard to have that beard completely covered, as well as hair. The CDM further confirmed she was unaware the freezer behind the Rock Creek Nurses Station had not been routinely temped, and was unaware of the Mighty Shakes being thawed without a thaw date documented on the cartons individually. She confirmed the damaged tiles on the floor presented an uncleanable surface, and had tried to have those repaired in the past. There was not a plan with a timeline to ensure those repairs.	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	F 880		2/13/23

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F 880	Continued From page 42	F 880		

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;
(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

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	535026	A. BUILDING _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	1851 BIG HORN AVE SHERIDAN, WY 82801

(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 880	Continued From page 43 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 and procedure review, the facility failed to ensure infection control practices were implemented for 4 random observations. The census was 77. The findings were: 1. Observation on 2/6/23 at 10:09 AM showed CNA #2 entered resident room 138 to obtain vital signs using a blood pressure cuff, oximeter, and a thermometer. The CNA exited resident room 138 and entered resident room 141 without cleaning the equipment between residents. Interview with the CNA at that time confirmed the equipment was not cleaned between residents. 2. Observations on 2/5/23 at 4:47 PM of resident dining showed LPN #2 obtained the blood glucose of a resident sitting at the dining table. The LPN failed to wear gloves while obtaining the blood glucose and no hand hygiene was observed after completion. Continued observation showed the LPN opened a medication bottle and inserted his ungloved finger inside the bottle to	F 880	F880 Standard and Transmission-Based Precautions (TBPs) PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND	

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F 880	Continued From page 44 retrieve a pill from the bottle and no hand hygiene was performed. Interview with the LPN at that time confirmed he should have worn gloves and did not perform hand hygiene. 3. Observation on 2/7/23 at 7:45 AM showed RN #2 removed a bottle of enteric coated 81 milligrams of aspirin from the medication cart, pour the aspirin into her ungloved hand, and transfer the aspirin into a medication cup. In addition, RN #2 removed individual resident bubble packs from the medication cart, pushed the medication from the packs into her ungloved fingers, and transfer the medication into a medication cup. Interview with RN #2 at that time confirmed she had used her bare hands and fingers when transferring medication from one location to another. 4. Observation on 2/7/23 at 7:55 AM showed RN #1 used a cloth from a bleach disinfectant container to wipe down a pulse oximeter, a thermometer and a blood pressure cuff. The RN wiped the equipment down in less than 10 seconds. The label on the disinfectant container showed "Disinfected in 4 minutes." Interview with the RN at that time confirmed the equipment dried in less than 4 minutes. She further stated she was not aware the equipment needed to stay wet for 4 minutes to obtain disinfection. 5. Interview on 2/7/23 at 3:23 PM with the infection preventionist revealed the expectation was to wear gloves when obtaining a blood glucose. He further stated the expectation was for staff to perform hand hygiene after obtaining a blood glucose, and while passing medications. Interview with the infection preventionist on 2/7/23 at 3:23 PM revealed the facility's expectation was	F 880	SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: One-on-one education provided to the two nurses found to be in deficient practice of hand hygiene when passing medications. Beginning 2/10/2023 all staff were educated on proper hand hygiene and PPE usage per CDC guidelines. Beginning 2/10/2023 all staff were educated on the dwell time of disinfectants and proper techniques for cleaning of equipment. All staff who are responsible for monitoring blood sugars have been educated on proper cleaning of glucometers and the length of dwell time for sanitation. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents are at risk by this deficient practice. II. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Root-cause analysis was conducted to	

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F 880	Continued From page 45 for staff to follow the manufacturer's instruction for disinfection. 6. Review of the facility policy "Obtaining a Fingerstick Glucose Level," with a revision date 10/11, showed "...Steps in the Procedure...5. Wear clean gloves...20. wash hands..." 7. Review of the "Handwashing/Hand Hygiene" policy, with a revision date 8/19 showed "...Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...c. before preparing or handling medications..." 8. Review of the facility policy "Cleaning and Disinfection of Resident-Care Items and Equipment," with a revision date 11/18 showed "...4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions..."	F 880	attempt to discover what the barrier to proper hand hygiene, PPE usage, and equipment cleaning is. Starting 2/10/2023, the facility began doing hand hygiene audits on all staff during random times in random areas weekly x 12, then monthly x 3. Beginning on 2/10/2023 all staff were audited on proper hand washing and PPE usage, visually by SDC or designee. Beginning 2/10/2023 audits will be done during med passes to ensure proper PPE and hygiene is being conducted weekly x 12, then monthly x 3. Beginning on 2/10/2023 audits will be done to monitor proper cleaning of re-uasable equipment weekly x 12, then monthly x 3. On 2/9/2023 SDC/IP contacted Mountain Pacific and received education and tools to use with staff. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to	

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F 880	Continued From page 46	F 880	follow up on any recommendations made by the QAPI Committee. Date of Compliance: 2/13/2023	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		3/1/23

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F 883	Continued From page 47 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a procedure to ensure residents, who had consented to receive an immunization, received the vaccine for 1 of 5 residents (#36) reviewed for immunizations. The findings were: 1. Review of the Pneumococcal and Influenza Immunization Consent Form showed resident #36 consented to both the pneumococcal and influenza vaccine on 9/1/22. The following concerns were identified: a. Review of the medical record showed the resident had refused both the pneumococcal and influenza vaccines. b. Review of the Rock Creek vaccination	F 883	F883 Influenza and pneumococcal immunizations PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN	

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F 883	Continued From page 48 worksheet, dated 10/18/22, showed the resident was sick at the time the vaccinations were given. A note on the worksheet revealed the resident wanted to be vaccinated when his/her current illness subsided. c. Interview with the infection preventionist on 2/8/23 at 8:39 AM confirmed the resident had not received the immunizations.	F 883	SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. ¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident # 36 has been reoffered influenza and pneumococcal vaccine and received per preference. Plan of care updated accordingly. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents who have requested a vaccine and still reside in the facility are at risk due to deficient practice. An audit of all residents completed. Residents who have requested a vaccine and still reside in the facility have been provided vaccine requested as eligible and plan of care updated accordingly. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:	

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F 883	Continued From page 49	F 883	All nurses have been educated by the DON/designee on vaccination process and notification to IPC if barrier is present. IPC/Designee will review all new admissions for vaccination preferences/requests weekly for 4 weeks, then monthly for 2 additional months. IPC/Designee will monitor all resident's vaccination status and offer as indicated; seasonal vaccines will be offered per CMS guidance. 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/1/2023	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:	F 887		3/1/23

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F 887	Continued From page 50 (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical	F 887		

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F 887	Continued From page 51 contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a procedure to ensure residents who had consented to receive the SARs-COV-2 vaccine/booster received the immunization for 1 of 5 residents (#14) reviewed. The findings were: 1. Review of the SARs-COV-2 education and consent form showed resident #14 had consented to receive the vaccination on 10/7/22. The following concerns were identified: a. Review of the facility's resident vaccination records received from the facility on 2/6/23 showed the resident was unvaccinated. b. Interview with the infection preventionist on 2/8/23 at 8:39 AM confirmed the resident had not received the vaccination and he was unable to locate any further documentation.	F 887	F887 COVID-19 Immunization PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. §488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.	

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F 887	Continued From page 52	F 887	¿ I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #14 has been reoffered SARs-COV-2 vaccine and received per preference. Plan of care updated accordingly. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents who have requested a vaccine are at risk due to deficient practice. Audit of all residents completed. Residents who have requested a COVID-19 vaccine have been provided vaccine requested as eligible and plan of care updated accordingly. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: All nurses have been educated by the DON/designee on vaccination process and notification to IPC if barrier is present. IPC/Designee will review all new admissions for COVID-19 vaccination preferences/requests weekly for 4 weeks, then monthly for 2 additional months. IPC/Designee will monitor all resident's vaccination status and offer as indicated. COVID-19 vaccines will be offered per	

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F 887	Continued From page 53	F 887	CMS guidance. ¿ 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. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The DON/Designee will be responsible to follow up on any recommendations made by the QAPI Committee. Date of Compliance: 3/1/2023	