STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/13/23 to 2/16/23. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide MA-C: Certified Medication Aide RN: Registered Nurse DON: Director of Nursing ADON: Assistant Director of Nursing IP: Infection Preventionist MDS: Minimum Data Set BIMS: Brief Interview for Mental Status RAI: Resident Assessment Instrument MAR: Medication Administration Record TAR: Treatment Administration Record HLS: Healthcare Licensing and Surveys (State Agency) Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		4/15/23

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

Electronically Signed | 03/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents or their representatives received written information about their right to formulate an advanced directive for 1 of 17 sample residents (#16). The findings were: 1. Review of the medical record for resident #16	F 578	The facility will ensure that resident or resident representative receives written information about their right to formulate an advance directive. This will be accomplished by: 1) Resident representative for resident #16 provided written education related to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 578	Continued From page 2 showed an election for do not resuscitate dated 3/22/22. Further review showed no evidence the resident or representative was provided written information about the right to formulate an advanced directive. 2. Interview with the MDS coordinator/IP on 2/15/23 at 7:59 AM revealed the resident was originally admitted for a respite stay and a modified admission packet was used. When the resident's stay was changed to long term, the normal admission documents were not completed. Further interview confirmed the resident's representative completed an advanced directive; however, the written education related to the resident's rights was not provided. 3. Review of the policy titled "Advance Directives" last revised 4/2008 showed "...1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives..."	F 578	resident's rights. 2) Utilizing the normal admission packet when a resident is admitted to ensure future residents are informed of their rights. 3) Updating the "Advance Directive" policy. Education of staff will occur for those involved with admissions. 4) The DON, or designee, will use an audit tool to audit 100% of resident charts to ensure that written education regarding resident rights and advance directives was provided. This audit will occur monthly. 5) The results of the audit will be presented to the QAPI committee for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F578.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 609	Continued From page 3 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of the HLS incident database, and policy and procedure review, the facility failed to ensure allegations of abuse were reported for 1 of 4 sample residents (#5) reviewed for abuse. The findings were: 1. Review of the quarterly MDS assessment dated 11/27/22 showed resident #5 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and diagnoses which included weakness and age-related osteoporosis without current pathological fracture. Further review showed the resident required extensive physical assistance of 1 person for bed mobility, transfers, dressing, and toilet use. The following concerns were identified: a. Review of a progress note dated 9/14/22	F 609	The facility will ensure reporting of alleged violations. This will be accomplished by: 1) Incident between resident #5 and resident #17 has been reported to the state. A facility investigation has been completed. 2) Utilizing our incident reporting system "Yellowstone" 3) An audit tool will be completed by the DON, or designee, to ensure all incidents are reported to the HLS incident database appropriately. A daily meeting will occur Monday through Friday to ensure alleged violations are reported and investigated appropriately. 4) Staff will be re-educated on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 609	Continued From page 4 and timed 10:37 PM showed the resident called out for help and staff found the resident on the floor in the chapel area. The resident was lying on his/her right side with resident #17 "standing over" him/her. The resident reported s/he asked resident #17 to move so resident #5 could see the TV and resident #17 "flipped my wheelchair over and that's how I ended up here." The resident repeated the scenario to other staff members. 2. Interview with the MDS coordinator/IP on 2/16/23 at 8:56 AM revealed the incident on 9/14/22 was an incident the facility would normally investigate as a resident to resident altercation or abuse. 3. Interview with the MDS coordinator/IP on 2/16/23 at 10:49 AM revealed the facility did not have evidence the incident was investigated and reported as abuse and confirmed it should have been. 4. Review of the HLS incident database showed no evidence a resident to resident altercation or allegation of abuse which involved resident #5 and resident #17 was reported. 5. Review of the policy titled "Abuse, Neglect and Exploitation" last revised on 10/2022 showed "...Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: 1. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or 2. Not later than 24 hours if the events that cause the	F 609	procedures in place to report any incidents that may occur. 5) The results of the audit will be presented to QAPI for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F609.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 609	Continued From page 5 allegation do not involve abuse and do not result in serious bodily injury..."	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were investigated for 1 of 4 sample residents (#5) reviewed for abuse. The findings were: 1. Review of the quarterly MDS assessment dated 11/27/22 showed resident #5 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and diagnoses which included weakness and age-related osteoporosis without current pathological fracture. Further review showed the resident required extensive	F 610	The facility will ensure alleged violations are investigated/prevented/corrected. This will be accomplished by: 1) The incident between resident #5 and resident #17 was reported to state. An internal investigation was completed. 2) Utilizing our incident reporting system "Yellowstone" 3) An audit tool will be completed by the DON, or designee, to ensure all incidents are reported to the "Yellowstone" system and investigated appropriately. Monthly	4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 610	Continued From page 6 physical assistance of 1 person for bed mobility, transfers, dressing, and toilet use. The following concerns were identified: a. Review of a progress note dated 9/14/22 and timed 10:37 PM showed the resident called out for help and staff found the resident on the floor in the chapel area. The resident was lying on his/her right side with resident #17 "standing over" him/her. The resident reported s/he asked resident #17 to move so resident #5 could see the TV and resident #17 "flipped my wheelchair over and that's how I ended up here." The resident repeated the scenario to other staff members. 2. Interview with the MDS coordinator/IP on 2/16/23 at 8:56 AM revealed the incident on 9/14/22 was an incident the facility would normally investigate as a resident to resident altercation or abuse. 3. Interview with the MDS coordinator/IP on 2/16/23 at 10:49 AM revealed the facility did not have evidence the incident was investigated and reported as abuse and confirmed it should have been. 4. Review of the policy titled "Abuse, Neglect and Exploitation" last revised on 10/2022 showed "...An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur..."	F 610	audit will be completed. 4) Alleged incidents will be discussed daily, Monday-Friday, by the DON, or designee, to identify incidents to be reported. 5) Re-education regarding the regulation was provided to staff responsible for reporting incidents. 6) Investigation form was created to ensure all allegations are investigated properly. 7) The results of the audit will be presented to QAPI for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F610.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 623		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 623	Continued From page 7 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	**713 OAK STREET SUNDANCE, WY 82729**

(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 623	Continued From page 8	F 623		

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

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 623	Continued From page 9 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents or residents' representatives received a written notice of transfer or discharge for 1 of 2 sample residents (#4) reviewed for hospitalization. The findings were: 1. Review of the resident progress notes showed resident #4 discharged from the facility on 2/9/23, with return anticipated. Further, the progress notes showed the resident returned to the facility on 2/14/23 with a diagnosis of pneumonia. Review of the medical record showed no evidence a written notice of transfer or discharge was provided to the resident, or resident's representative, at the time of transfer. 2. Interview with the MDS coordinator/IP on 2/16/23 at 11:01 AM revealed the facility did not think to provide a written transfer or discharge form since the hospital was "right next to us, and the resident was acute."	F 623	The facility will ensure resident/resident representative will be provided written notice of transfer/discharge. This will be accomplished by: 1) Educating nurses about the regulation. 2) Resident #4 was given written notice of transfer for past incident. 3) The transfer checklist will be updated to include "written notice to resident/resident representative" to ensure that it is provided upon transfer. 4) The DON, or designee, will perform a monthly audit on any transfers/discharges to ensure the written notice was provided. 5) The results of the audit will be presented to the QAPI committee for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F623.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 625	Continued From page 10 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure residents or residents' representatives received a written notice of bed-hold for 1 of 2 sample residents (#4) reviewed for hospitalization. The findings were: 1. Review of the resident progress notes showed	F 625	The facility will ensure resident/resident representative will be provided the bed-hold policy for each transfer/discharge. This will be accomplished by: 1) Educating nurses about the regulation. 2) Resident #4 was provided with written	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 625	Continued From page 11 resident #4 discharged from the facility on 2/9/23, with return anticipated. Further, the progress notes showed the resident returned to the facility on 2/14/23 with a diagnosis of pneumonia. Review of the medical record showed no evidence a written notice of bed-hold policy was provided to the resident, or resident's representative, at the time of transfer. 2. Interview with Interview with the MDS coordinator/IP on 2/16/23 at 11:01 AM revealed the facility the facility had the resident or resident representative sign a bed hold at the time of admission to the facility. Further interview revealed the facility did not provide a written bed hold policy for each discharge or transfer.	F 625	bed-hold policy for past incident. 3) The transfer checklist will be updated to include "bed-hold policy" to ensure that it is provided upon transfer. 4) The DON, or designee, will perform a monthly audit on any transfers/discharges to ensure the bed-hold policy was provided. 5) The results of the audit will be presented to the QAPI committee for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F625.	
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 observation, medical record review, staff interview, and review of the MDS RAI 3.0 manual, the facility failed to ensure MDS assessments were accurately coded for 1 of 17 sample residents (#3). The findings were: 1. Review of quarterly MDS assessment dated 11/17/22 showed resident #3 had diagnoses which included cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke and no functional limitation in range of motion in the upper or lower extremities. The findings were: a. Observation on 2/13/23 at 4:49 PM showed the resident appeared to have	F 641	The facility will ensure MDS assessments are accurately coded. This will be accomplished by: 1) The MDS coordinator will correct the "significant error" in the MDS assessment for the resident stated in the SOD. 2) DON, or designee, will educate MDS coordinator on proper steps to take to correct significant errors. 3) The MDS coordinator, or designee, will perform an audit on all assessments to ensure proper coding was done on all other residents. 4) The results of the will be presented to	4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 641	Continued From page 12 contractures and limited range of motion in his/her right hand and right arm. b. Observation on 2/15/23 at 8:51 AM showed the resident was able to independently propel him/herself in the wheelchair; however, the resident only used his/her left leg and rested the right leg on top of the left leg while propelling. Further observation showed the resident's left arm was used to push the wheelchair wheel and the resident's right arm was positioned on his/her torso. c. Review of the annual MDS assessment dated 8/18/2022 assessment showed the resident had functional limitation in range of motion on 1 side of his/her upper extremities and no impairment of the lower extremities. d. Interview with the MDS coordinator/IP on 2/16/23 at 8:58 AM revealed the resident's right lower extremity could still be used; however, it was more passive and the resident did have limited range of motion of the right upper extremity. Further interview confirmed the 11/17/22 quarterly MDS assessment was not accurately coded related to the resident's functional limitation in range of motion. 2. Review of the "CMS RAI version 3.0 manual, October 2019" showed "...A "significant error" is an error in an assessment where: 1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and 2. The error has not been corrected via submission of a more recent assessment..."	F 641	the QAPI committee to ensure continued compliance for a minimum of three months or until QAPI committee is satisfied that the facility is in compliance with F641.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 689	Continued From page 13 §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 §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, staff interview, and review of policy and procedures, the facility failed to ensure assistive devices were functioning appropriately for 4 of 4 sample residents (#7, #15, #16, #17) reviewed for elopement. The findings were: 1. Review of the quarterly MDS assessment dated 12/20/22 showed resident #7 had a BIMS score of 3 out of 15, which indicated sever cognitive impairment, and diagnoses which included non-Alzheimer's dementia. Further review showed a wander/elopement alarm was used daily. The following concerns were identified: a. Review of a progress note dated 9/7/22 and timed 3:34 PM showed the resident was pacing" and looking for his/her car. The resident was "mad" for being "dumped" at the facility. Further review showed the resident "exited the building 3 times" and a wander-guard was placed. b. Observation on 2/13/23 at 3:35 PM showed resident #7 and resident #16 ambulating in the facility hallway. The residents attempted to go out the main doors; however, they attempted to push the door out and the hinges swung in. The residents turned and ambulated toward the desk and down the other hallway. Continued observation showed the residents entered several	F 689	The facility will ensure residents are free of accident hazards/supervision/devices. This will be accomplished by: 1) All wanderguards were checked for resident #7, #15, #16, #17 to ensure they are working appropriately. 2) All residents with wanderguards will be identified and wanderguards will be checked to ensure they are working appropriately. 3) Placing a "wanderguard check" task in the TAR. Weekly checks will be done to ensure wanderguards are working appropriately. 4) An audit of the check will be completed by the DON, or designee, weekly to identify any disfunction of the wanderguard. 5) Staff will be educated on the importance of checking wanderguards weekly to ensure resident safety. 6) The results of the audit will be presented to QAPI to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F689.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 689	Continued From page 14	F 689		

rooms looking for resident #7's cat.

c. Review of the care plan last reviewed on 1/11/23 showed no evidence of a wander-guard placement or routine checks to ensure proper function.

d. Review of the MAR/TAR for December 2022, January 2023, and February 2023 showed no evidence of wander-guard placement or routine checks to ensure proper function.

2. Review of the quarterly MDS assessment dated 1/2/23 showed resident #16 had a BIMS score of 3 out of 15, which indicated sever cognitive impairment, and diagnoses which included Alzheimer's disease. Further review showed a wander/elopement alarm was used daily. The following concerns were identified:

a. Review of a progress note for resident #16 dated 9/20/22 and timed 10:55 PM showed "resident continued to pace and attempt to open the office doors from 1800-2100 [6 PM to 9 PM]. Asking why we are keeping [him/her] here and looking for [his/her] truck..."

b. Observation on 2/13/23 at 3:35 PM showed resident #7 and resident #16 ambulating in the facility hallway. The residents attempted to go out the main doors; however, they attempted to push the door out and the hinges swung in. The residents turned and ambulated toward the desk and down the other hallway. Continued observation showed the residents entered several rooms looking for resident #7's cat.

c. Review of the care plan last reviewed on 1/18/23 showed no evidence of a wander-guard placement or routine checks to ensure proper function.

d. Review of the MAR/TAR for December 2022, January 2023, and February 2023 showed no evidence of wander-guard placement or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	**713 OAK STREET SUNDANCE, WY 82729**

(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 689	Continued From page 15 routine checks to ensure proper function. 3. Review of the quarterly MDS assessment dated 12/7/22 showed resident #15 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia. Further review showed the resident's balance was not steady and s/he wore a wander-guard. The following concerns were identified: a. Review of the MAR/TAR for December 2022, January 2023, and February 2023 showed no evidence of wander-guard placement or routine checks to ensure proper function. 4. Review of the quarterly MDS assessment dated 1/4/23 showed resident #17 had short-term and long-term memory problems and diagnoses which included Alzheimer's disease, anxiety disorder, sensorineural hearing loss, and macular degeneration. Further review showed the resident was independent and required set-up help only for bed mobility, transfers, walking in and out of the room, and locomotion on the unit, and a wander/elopement alarm was used daily. a. Observation on 2/14/23 at 9:43 AM showed resident #17 was wandering in the unit. b. Review of the care plan titled "I am an elopement risk/wanderer AEB [as evidenced by] history of attempts to leave the facility unattended, impaired safety awareness, inability to redirect my behavior, poor safety awareness, resident wanders aimlessly, significantly intrudes on the privacy of others" last reviewed on 1/18/23 showed the resident had a wander-guard on his/her ankle. There were no routine checks to ensure proper function. d. Review of the MAR/TAR for December 2022, January 2023, and February 2023 showed	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 689	Continued From page 16 no evidence of wander-guard placement or routine checks to ensure proper function. 5. Interview with the MDS coordinator/IP on 2/16/23 at 11:08 AM confirmed the residents all had a wander-guard in use and the facility had previously placed wander-guard checks on the TAR to ensure the system was functioning correctly. Further interview confirmed the facility was unable to prevent residents from leaving the facility if the system was not functioning correctly. 6. Review of the policy titled "Elopements and Wandering Residents Policy and Procedure" last revised 8/2016 showed "...6. Monitoring and Managing at Risk for Elopement or Unsafe Wandering...e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly..."	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced	F 727		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 727	Continued From page 17 by: Based on staff schedule review, payroll based journal report review, and staff interview, the facility failed to ensure the services of an RN were utilized for 8 consecutive hours per day, 7 days per week for 5 of 5 months (Oct. 2022, Nov. 2022, Dec. 2022, Jan. 2023, Feb. 2023) reviewed. The facility census was 23. The finding were: 1. Review of the payroll based journal report showed "No RN Hours" "triggered (Four or More Days within the Quarter with no RN hours)" or was "not reported" during quarter 2, 3, and 4 of 2022 and quarter 1 of 2023. 2. Review of the nursing schedule for October 2022 showed the facility failed to provide RN services for 8 consecutive hours on 4 of 31 days, on 10/5, 10/6, 10/8, and 10/9. 3. Review of the nursing schedule for November 2022 showed the facility failed to provide RN services for 8 consecutive hours on 5 out of 30 days, on 11/5, 11/6, 11/19, 11/20, and 11/26. 4. Review of the nursing schedule for December 2022 showed the facility failed to provide RN services for 8 consecutive hours on 5 out of 31 days, on 12/3, 12/4, 12/17, 12/18, and 12/24. 5. Review of the nursing schedule for January 2023 showed the facility failed to provide RN services for 8 consecutive hours on 5 out of 31 days, on 1/7,1/8, 1/21, 1/22, and 1/29. 6. Review of the nursing schedule for February 2023 showed the facility failed to provide RN services for 8 consecutive hours on 2 of 15 days,	F 727	The facility will ensure that theres is RN coverage 8 consecutive hours a day, 7 days a week. This will be accomplished by: 1) Scheduling a RN for at least 8 hours a day, 7 days a week; this may include the infection control RN, PRN RN, LTC supervisor, or DON. 2) The posted nurse staffing sheet will reflect that there is coverage 8 consecutive hours a day, 7 days a week. 3) The CEO will ensure that there is a RN for 8 consecutive hours, 7 days a week. Nursing staff will be re-educated on the regulation. 4) This facility will continue to offer a sign-on bonus, employee referral incentive, and competitive hourly wage for registered nurses in an ongoing attempt to attract and hire additional registered nurses. 5) The results of the audit will be presented to QAPI for a minimum of three months or until QAPI committee is satisfied that the facility is in compliance with F727.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 727	Continued From page 18 on 2/4 and 2/5. 7. Interview with ADON/Scheduler on 2/15/23 at 2:55 PM confirmed she failed to ensure an RN was scheduled to cover 8 consecutive hours per day, 7 days per week.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 732	Continued From page 19 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 staff posting, and staff interview the facility failed to ensure the required daily staff posting was available in 1 of 1 skilled area. The census was 23. The findings were: 1. Observation on 2/13/23 at 5:32 PM showed the staff posting was in the entrance hall and the facility posted the proposed weekly staffing hours instead of the daily staff posting and actual hours worked. 2. Review of one month of staff postings showed the facility always posted the proposed weekly staffing hours instead of the daily staff posting and actual hours worked. 2. Interview with the MDS coordinator/IP on 2/15/23 at 2:59 PM confirmed the staff posting was not posted daily. Further interview revealed the "Sunday night nurse" would post the information for the week and it was unknown if it was ever updated with any changes to reflect actual hours worked.	F 732	The facility will ensure that nurse staffing is posted daily. This will be accomplished by: 1) DON, or designee, will edit the nurse staffing sheet for daily posting instead of weekly posting. 2) DON, or designee, will complete daily staffing sheet at the beginning of the AM shift (6am) and post actual worked hours in the entrance hall of the facility. 3) The DON, or designee, will create an audit form to ensure staffing information is posted daily. 4) The DON, or designee, will present the results of the audit to the QAPI committee to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F732.	
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	F 758		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 20	F 758		

affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 21 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and policy and procedure review, the facility failed to ensure as needed (PRN) orders for anti-psychotic medications were limited to 14 days for 2 of 6 sample residents (#7, #22) and failed to ensure appropriate behavior monitoring and non-pharmacological interventions were in place for 2 of 6 sample residents (#7, #22) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated 12/20/22 showed resident #7 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia and depression. Review of February 2023 physician orders showed the resident received trazodone (antidepressant) 50 milligrams (mg) by mouth daily at bedtime and Ativan (anti-anxiety) 0.5 mg by mouth twice per day as needed (PRN). The following concerns were identified: a. Review of the MAR and TAR for February 2023, January 2023, and December 2023 showed no evidence of medication-specific target symptoms or non-pharmacological interventions identified. b. Review of the current physician orders showed the resident was ordered Ativan for anxiety on 9/7/22 as needed and no stop date was identified. Review of the electronic medical	F 758	The facility will ensure that residents are free from unnecessary psychotropic medication use and identify appropriate diagnoses and target symptoms and monitor the drug use appropriately. This will be accomplished by: 1) IDT will review care plans for resident #7, #22 and identify target symptoms for the use of psychotropic medications. 2) Target symptoms will be added to the TAR and monitored daily. 3) Care plans for resident #7, #22 will be updated to reflect target symptoms of antipsychotic medication use. 4) 100% of resident care plans will be audited to identify that each resident has target symptoms identified if psychotropic medications are used. 4) The "Resident Psychotropic Medication Use" form will be audited to identify root cause of missed target symptoms. 5) Staff will be re-educated on regulation. 6) An audit, completed by DON or designee, will be completed on 100% of the residents to ensure target symptoms are identified for all psychotropic medication use and stop/end dates have been utilized. 7) The results of this audit will be presented to QAPI committee to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 22 record showed no evidence of a physician assessment or rationale for use of a PRN psychotropic medication greater than 14 days. 2. Review of the admission MDS assessment dated 12/23/22 showed resident #22 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia, anxiety disorder, and depression. Review of the February 2023 physician orders showed the resident received trazodone (antidepressant) 50 milligrams (mg) by mouth daily at 6 PM, quetiapine (antipsychotic) 50 mg by mouth twice per day, sertraline (antidepressant) 100 mg by mouth daily at 8 AM, and Ativan (anti-anxiety) 0.5 mg by mouth twice per day as needed (PRN). The following concerns were identified: a. Review of the MAR and TAR for February 2023, January 2023, and December 2023 showed no evidence of medication-specific target symptoms or non-pharmacological interventions identified. b. Review of the current physician orders showed the resident was ordered Ativan for anxiety on 12/16/22 as needed and no stop date was identified. Review of the electronic medical record showed no evidence of a physician assessment or rationale for use of PRN psychotropic medication greater than 14 days. 2. Interview with the MDS coordinator/IP on 2/16/23 at 9:06 AM revealed the residents did not have identified target symptoms or non-pharmacological intervention monitoring specific to the use of the psychotropic medications either resident. Further interview confirmed there was no physician rationale for extended use of the PRN psychotropic	F 758	continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F758.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 23 medications. 3. Review of the policy titled "Psychotropic Medication and Gradual Dose Reduction" last revised 3/2022 showed "...9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days)....12. Use of psychotropic medications in specific circumstances:...b. Enduring conditions (i.e., non0acute, chronic, or prolonged): 1. The resident's symptoms and therapeutic goal shall be clearly and specifically identified and documented..."	F 758		
F 851 SS=C	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long	F 851		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 851	Continued From page 24 term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by:	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 851	Continued From page 25 Based on payroll based journal data review and staff interview, the facility failed to ensure payroll based journal (PBJ) data was submitted quarterly for 2 of 4 quarters (3rd quarter 2022, 4th quarter 2022) reviewed. The census was 23. The findings were: 1. Review of PBJ staffing data for quarters 2, 3, and 4 of 2022 and quarter 1 of 2023 showed the facility failed to submit PBJ data for quarter 3 and quarter 4 of 2022. 2. Interview with the CFO on 2/15/23 at 2:14 PM revealed she was responsible for submitting PBJ data and the facility had failed to submit the information into PBJ as scheduled by CMS.	F 851	The facility will ensure that payroll based journal data (PBJ) is submitted quarterly. This will be accomplished by: 1) System issues that resulted in failed submissions to PBJ as scheduled by CMS has been resolved. 2) DON, or designee, will submit PBJ data quarterly. 3) An audit will be done quarterly to ensure data has been submitted on time. 4) DON, or designee, will be educated on reporting rules. 5) The results of the audit will be presented to QAPI to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F851.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 867	Continued From page 26 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 867	Continued From page 27	F 867		

safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 867	Continued From page 28 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interview, and review of compliance history information, the facility failed to develop and implement policies and procedures for how it will develop, monitor and evaluate performance indicators to prevent repeat deficiencies from previous surveys. The census was 23. The findings were: 1. Review of the Casper 3 report last updated on 2/8/23 showed F727 was previously cited on 3/2/22, F758 was previously cited on 3/2/22, and F880 was previously cited on 3/2/22 as well as in 2021 and 2018. 2. Interview with the ADON on 2/16/23 at 1:09 PM revealed the QAPI committee did not discuss the areas identified as repeat deficient practice during the QAPI meetings and the facility was not working on any performance improvement plans related to any of the areas identified as repeat deficient practice.	F 867	The facility will ensure appropriate plans of action are developed and implemented to prevent repeat deficiencies. This will be accomplished by: 1) The QAPI leader, or designee, will develop a QA plan to monitor for deficiencies cited during surveys in order to ensure continued compliance. 2) Weekly chart audits will be performed by QAPI leader, or designee, to review for mention of possible incidents that might require further investigation and follow up with staff and continued surveillance utilizing Yellowstone Event reporting system. 3) Reeducating staff at upcoming staff meeting (4/5/2023) on charting requirements and procedures. 4) The QAPI leader, or designee, will present the results of the audit to the QAPI committee to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 867	Continued From page 29	F 867	facility is in compliance with F867.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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	F 880		4/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 30 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 review of Centers for Disease Control (CDC) guidelines the facility failed to ensure infection control techniques were implemented to prevent spread of COVID-19 during 7 random observations. The census was 23. The findings were: 1. Observation of room 202 on 2/13/23 at 4:51	F 880	The facility will ensure proper infection prevention and control techniques are utilized to prevent the spread of infectious diseases. This will be accomplished by: 1) All nurse/aides will receive education at the next staff meeting on donning/doffing PPE.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 31 PM showed the room was on transmission-based precautions due to COVID-19 and the door was open. Further observation showed the room was located across from the main dining area and the door remained open until 5:30 PM, which included the time during the dinner meal. 2. Observation of room 203 on 2/13/23 at 5:08 PM showed the room was located across from the main dining area, was on transmission-based precautions due to COVID-19 and the door was left open. Observation on 2/14/23 at 8:15 AM showed the door was open. 3. Observation of room 217 on 2/15/23 at 4 PM showed the room was on transmission-based precautions and the door was open. 4. Interview with the MDS coordinator/IP on 2/16/23 at 12:47 PM revealed the facility expected isolation room doors to remain closed while on precautions for COVID-19. 5. Observation showed on 2/13/23 at 5:04 PM MA-C #1 donned PPE in the hall and entered room 203. Upon exit, the MA-C doffed the PPE in the hall and discarded it in the trash between room 203 and room 202. Observation on 2/13/23 at 5:19 PM showed the MA-C exited room 202 and doffed the PPE in the hall and discarded it in the trash between room 202 and 203. 6. Observation on 2/14/23 at 9:17 AM showed CNA #1 donned PPE which included a gown, N95 mask, goggles, and gloves in the hall outside room 202 and entered room 203. Upon exit, the CNA doffed the PPE while standing near the isolation cart outside room 202. After removing her mask, the CNA removed the goggles and	F 880	2) All staff will have to show IP or designee that they can don/doff PPE correctly to ensure future compliance and appropriate infection control practices. 3) Signs will be posted "KEEP DOOR CLOSED" on infectious rooms. 4) An audit of staff by DON, or designee, will be done to ensure everyone has received education and demonstrated proper techniques. Each outbreak will be audited to ensure staff working during that time have received education on donning/doffing. 5) Donning/Doffing process will be given to new employees. 6) The DON, or designee, will present the results of the audit to the QAPI committee to ensure continued compliance for a minimum of 3 months or until QAPI committee is satisfied that the facility is in compliance with F880.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	713 OAK STREET SUNDANCE, WY 82729

(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 32	F 880		

placed them on top of the isolation cart. The CNA performed hand hygiene, applied clean gloves, and wiped the goggles with a wipe obtained from the isolation cart. The CNA performed hand hygiene and donned PPE which included a gown, N95 mask, gloves, and the goggles she had just wiped, and entered room 202. Upon exit, the CNA doffed the PPE while standing near the isolation cart outside room 202. After removing her mask, the CNA removed the goggles and placed them on top of the isolation cart. The CNA performed hand hygiene, applied clean gloves, and wiped the goggles with a wipe obtained from the isolation cart. The CNA immediately placed the goggles in the top of the cart, donned a surgical mask, and left the area. No sanitation of the top of the isolation cart, where the goggles were placed, was performed and all PPE items were discarded in a trash between room 202 and 203.

7. Interview with CNA #1 on 2/14/23 at 9:28 AM revealed staff doff PPE outside the room; however, "It probably should be done inside the room."

8. Interview with the MDS coordinator/IP on 2/16/23 at 12:47 PM revealed the rooms were crowded so staff doffed PPE outside the room. She revealed the contact time for the solution used to sanitize goggles was "1 minute" and nothing contaminated should be placed on top of the isolation cart; however, if items were placed on top of the cart, staff were expected to sanitize the cart. Further interview revealed a staff member's mask should be replaced as soon as one was removed when donning or doffing PPE.

9. Review of "https://www.cdc.gov/coronavirus/2019-ncov/hcp/i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	**713 OAK STREET SUNDANCE, WY 82729**

(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 33 nfection-control-recommendations.html" accessed on 2/24/23 showed "...Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom. If cohorting, only patients with the same respiratory pathogen should be housed in the same room..." 10. Review of the "https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html" showed "...Use personal protective equipment (PPE) appropriately, including gloves and gown. ...Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens..."	F 880		