STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 4/10/23 to 4/13/23. Also reviewed in the course of the survey was complaint intake WY00003571. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing EVS: Environmental Services LPN: Licensed Practical Nurse MA: Medication Assistant MAR: Medication Administration Record MDS: Minimum Data Set NHA: Nursing Home Administrator NSA: Nutrition Support Aide RN: Registered Nurse	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		5/1/23

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

Electronically Signed | 05/03/2023

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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of the facility investigation report, staff and resident representative interview, review of policy and procedure, review of facility training documentation, and State Survey Agency incident report review, the facility failed to protect the residents right to be free from physical abuse by staff for 1 of 1 sample residents (#23) reviewed for abuse allegations. The findings were: 1. Review of the 2/7/23 quarterly MDS assessment showed resident #23 had a staff assessment which determined the resident was severely cognitively impaired. The resident exhibited physical behavioral symptoms directed toward others; behavioral symptoms not directed toward others; and rejection of care 4 to 6 days of the 7-day look-back period. In addition, the resident exhibited verbal behavioral symptoms directed toward others 1 to 3 days of the look-back period. Review of State Survey Agency incident reports showed an allegation of abuse was reported by the facility on 4/3/23 at 9:33 AM. The following concerns were identified: a. Interview with EVS #1 on 4/12/23 at 9:25 AM revealed she was mopping the dining room floor at the end of the noon meal when she witnessed an incident between NSA #1 and the resident. EVS #1 stated NSA #1 was attempting to remove a soiled clothing protector from the resident; however, the resident was resisting and saying "no, no, no". NSA #1 continued to attempt to remove the clothing protector and the resident reached over and grabbed NSA #1's arm. NSA #1 reacted by yelling at the resident "You won't treat me like that" and slapping the resident's face. EVS #1 stated she was only 10 to 15 feet away	F 600	1. Employee who reported potential abuse was counseled on reporting abuse immediately and assured there would not be retaliation. Education was done with her regarding the need to report any abuse or suspected abuse immediately. 2. Long term care staff were re-educated on the Abuse policy between 4/4/2023 and 4/15/2023. 3. NSAs and CNAs were also educated on caring for the Dementia patient on 4/5/23. 4. All facility staff Abuse education due 6/30/2023 via HealthStream. 5. Any report of abuse will result in an investigation. 6. Abuse Policy will be review in monthly QA.	

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and could hear the slap. Afterward, the resident had a stunned expression on his/her face.

b. Interview with NSA #2 on 4/12/23 at 4:41 PM revealed she was seated at the computer desk at the back of the dining room at the time of the incident. NSA #2 stated she heard a commotion between NSA #1 and the resident about a clothing protector and witnessed the resident grab NSA #1's arm; however, she did not see or hear a slap. Review of an interview by the facility with NSA #2 dated 4/3/23 and timed 11:45 AM showed "[NSA #2] freely gave information that she is very hard of hearing in her left ear which was the ear that was turned towards the event taking place and she was a good 30 feet or more from the occurrence..."

c. Interview with NSA #1 on 4/12/23 at 8:50 AM revealed she was going to take the resident out of the dining room after the noon meal and attempted to remove her soiled clothing protector. NSA #1 stated the resident resisted the removal of the clothing protector and the NSA tried to trade a clean clothing protector for the soiled one; however, the resident did not want it. NSA #1 stated the resident grabbed her "hard leaving a bruise" and "spit" on her. NSA #1 stated she remembered she raised her hand; however, "honestly, do not remember making any contact with the resident". NSA #1 stated when the resident was resisting or rejecting care the approach was supposed to be leave the resident alone and "that is what I probably should have done."

d. Interview with the resident's representative on 4/11/23 at 9:23 AM revealed he was aware of an investigation being conducted related to an incident where an aide allegedly slapped the resident. He thought it might have been a defensive move since the resident did strike out

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F 600	Continued From page 3	F 600		

at people and perhaps the aide was not properly trained. The resident's representative stated if the resident was being resistant it was best to leave him/her alone for a few minutes and s/he would forget all about it and be fine.

e. Review of a statement provided to the facility from MA #1 dated 4/3/23 and timed 10:30 AM showed she had wheeled the resident out of the dining room after the incident and the resident was pleasant and did not have any marks on his/her face.

2. Interview with the DON on 4/13/23 at 10:58 AM revealed the facility had erred on the side of the resident and had terminated NSA #1's employment. In addition, the facility had an in-service in January 2023 which included abuse and reporting. After the incident occurred the DON went to each staff member and verbally instructed them on abuse and reporting and provided them a copy of the abuse policy. However; review of the "Abuse, Prevention of abuse and Abuse reporting policy" education form showed only 23 employees had been educated from 4/4/23 to 4/13/23. Review of the personnel roster showed the facility had 128 employees and 6 volunteers.

3. Review of the "Abuse/Neglect Policy", last reviewed 9/2022, showed "It is the policy of Weston County Manor that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion...Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff

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F 600	Continued From page 4 and other applicable individuals in techniques to protect all parties."	F 600		
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 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 review of facility policies, the review of State Survey Agency incident report logs, and staff interview, the facility failed to develop and/or	F 609	1. Reviewed Abuse policy with EVS#1 regarding reporting abuse immediately on 4/3/2023.	5/1/23

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F 609	Continued From page 5 implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act for 1 of 1 allegations of abuse reviewed. The findings were: 1. Review of the facility's policy "Abuse/Neglect Policy", last reviewed 9/2022 showed "...a. Employees must always report any abuse or suspicion of abuse immediately to the Administrator or designee...Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located, any reasonable suspicion of a crime against any individual who is a resident of or is receiving care from, the facility, and each covered individual shall report immediately, but not more than 2 hours after forming the suspicion..." Review of the State Survey Agency incident report logs showed an allegation of abuse was reported by the facility on 4/3/23 at 9:33 AM. The following concerns were identified: a. Interview with EVS #1 on 4/12/23 at 9:25 AM revealed she had witnessed an incident between resident #23 and NSA #1 which she thought was abusive on 4/2/23 at approximately 1:15 PM in the facility's dining room. EVS #1 stated she did not immediately report the incident; however, she contacted MA #1 later in the afternoon. b. Interview with MA #1 on 4/13/23 at 1:21 PM revealed she had spoken to EVS #1 after 6 PM on 4/2/23 and then spoke with the former DON at approximately 6:50 PM to report the incident. 2. Interview with the DON on 4/13/23 at 10:58 AM confirmed the allegation of abuse occurred on	F 609	2. Education was done with the DON regarding reporting all Abuse and suspected abuse to the State Agency within 2 hours, by Interim CEO. 3. Education was done with the DON regarding reporting to Law Enforcement entities any reasonable suspicion of a crime againt an individual who is a resident of or is receiving care from the facililty, by Interim CEO. 4. Monitoring will be done any report of abuse will audited for timely reporting and investigation by DON and CEO.	

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F 609	Continued From page 6 4/2/23 at approximately 1:30 PM and was witnessed by EVS #1 who did not immediately report the incident because she was afraid of retaliation. The DON stated the incident was first communicated to MA #1 who then informed the former DON. The DON stated the former DON trained her on the use of the State Survey Agency incident reporting database on 4/3/23 and this was when the allegation of abuse was reported. In addition, the DON stated the police were not notified.	F 609		
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- (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	F 623		5/1/23

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F 623	Continued From page 7	F 623		

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 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

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F 623	Continued From page 8 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 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 provide a written notice of transfer and notify the ombudsman for 1 of 2 sample residents (#90) reviewed for a facility-initiated transfer. The findings were: 1. Review of the medical record for resident #90 showed the resident was hospitalized on 4/1/23	F 623	1. Resident #90's representive was notified of transfer on 4/1/2023 via telephone and it was documented in the clinical record and the ombudsman was notified on 5/2/2023, with a written transfer notice. 2. All resident transfers will be reported to the resident and the resident's	

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F 623	Continued From page 9 following an acute change of condition and readmitted to the facility on 4/7/23. There was no evidence a written transfer notice had been provided to the resident's representative or the ombudsman had been notified. 2. Interview with the DON on 4/13/23 at 10:32 AM confirmed a written transfer notice had not been provided to the residents representative or the ombudsman notified.	F 623	representative verbally and in writing this will be documented in the resident chart. 3. All resident transfers will be reported to the ombudsmen monthly in writing by the Social Worker 4. Monitoring will be complete monthly by the DON and reported at monthly QA. 5. Completed by 5/1/2023. 6. Audit of the last 30 days for transfers were done to ensure residents, their representative and the ombudsmen were notified. 7. Eduction was done at the staff meeting on 4/27/2023 by DON	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the 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	F 656		5/1/23

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F 656	Continued From page 10 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure 1 of 12 sample residents (#10) had resident-specific care plans that reflected individual needs in all required areas. The findings were: 1. Review of the 2/13/23 quarterly MDS assessment showed resident #10 had a BIMS score of 14 out of 15, indicating the resident was cognatively intact, and had diagnoses which included coronary artery disease, heart failure, anxiety disorder, and an unspecified pulmonary disorder. Further review showed the resident	F 656	1. Resident #10 care plan was updated on 4/16/2023 to include oxygen 3-4 liters day and night continuous. 2. All residents with supplemental oxygen and their respective care plans were reviewed to ensure a person-centered care plan had been developed in regard to the resident's use of supplemental oxygen. 3. MDS coordinator was educated on 4/17/2023 on reviewing and updating care plans with supplemental oxygen, by DON 4. Monitoring will be completed by DON or designee for compliance and will be	

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F 656	Continued From page 11 required supplemental oxygen. Review of the physician orders showed the resident was prescribed 3 to 4 liters per minute of continuous oxygen via a nasal cannula every day and night with a start date of 10/7/22. The following concerns were identified: a. Observation on 4/11/23 at 9:58 AM showed the resident was in his/her recliner receiving oxygen through a nasal cannula from a concentrator. Interview with the resident at that time revealed s/he required continuous supplemental oxygen at 3 to 4 liters per minute. The resident stated the nasal cannula hurt his/her nose and s/he would prefer to have an oxygen mask; however, when s/he asked, the facility had refused. b. Review of the resident's care plan, last revised 2/22/23, showed no evidence a person-centered care plan had been developed in regard to the resident's use of supplemental oxygen. c. Interview with the DON on 4/13/23 at 10:46 AM confirmed the care plan did not include the resident's use of supplemental oxygen. In addition, the DON stated she was unaware of the resident's request for an oxygen mask.	F 656	reported monthly at QA. 5. Completed 05/01/2023	
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities	F 680		5/28/23

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F 680	Continued From page 12 professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to to ensure the activities program was directed by a qualified professional. The census was 39. The findings were: 1. Random observations from 4/10/23 to 4/13/23 in the solarium and activities room showed residents participating in various activities. 2. Interview on 4/10/23 at 3:39 PM with the activities director revealed she had not completed the special training needed to coordinate the program. 3. Interview on 4/12/23 at 10:16 AM with the human resources director confirmed the activities director had not completed the training required to coordinate the activities program.	F 680	1. Activities Director is currently enrolled and in the process of completing the certification at Casper College. 2. Activities Director has completed 2 of the 6 modules required. 3. Activities Director will have the training completed by 5/28/2023, progress will be monitored weekly by DON. 4. The activities department will be coordinated by our Occupational Therapists until the Activities Director completes her training. 5. Job description will be updated to state Activities Director has to be certified or or report to a consultant who is an OT or COTA. If the Activities Director is not certified at the time of hire he/she will have 45 days to complete the certification from their start date.	
F 727 SS=E	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	F 727		5/1/23

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F 727	Continued From page 13 least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of staff schedules, and review of the Staffing Data Submission Payroll Based Journal (PBJ) report, the facility failed to ensure an RN worked at least 8 consecutive hours within each 24 hour period, 7 days a week. The census was 39. The findings were: 1. Review of the PBJ report showed no RN coverage for 8 consecutive hours in a 24 hour period for the following 12 days: 5/14/22 and 5/15/22, 6/5/22, 6/11/22 and 6/16/22, 8/6/22 and 8/7/22, 10/1/22 and 10/2/22, 11/13/22, 12/10/22 and 12/11/22. Further review of the facility staff schedules showed no RN coverage for the following 8 days: 10/30/22, 11/11/22, 11/27/22, 1/8/23, 2/4/23, 2/5/23, 2/17/23 and 2/18/23. 2. Interview with the DON on 4/13/23 at 2:34 PM revealed s/he could not recall the facility having a day without an RN present in the building; however, due to a new scheduling program she was unable to provide evidence RN staffing requirements were met.	F 727	1. The schedule was reviewed on 4/11/2023 by the DON to ensure an RN is on every day for eight consecutive hours per day. 2. The DON will review the schedule weekly to ensure an RN is scheduled for 8 continuous hours each day to ensure all residents are not at risk. 3. Educated DON on the requirement on 4/13/2023, by Interim CEO. 4. Monitoring will be completed by the weekly review of the schedule showing that an RN is scheduled for 8 continuous hours each day and will be completed by DON or designee for compliance and will report at monthly QA. 5 Completed 5/1/2023.	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40	F 740		5/1/23

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F 740	Continued From page 14 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and facility policy review, the facility failed to ensure the provision of necessary behavioral health care and services for 1 of 4 sample residents (#27) reviewed for behaviors. The findings were: 1. Review of the 2/14/23 significant change MDS assessment for resident #27 showed the resident had a BIMS score of 6 out of 15 indicating the resident had severe cognitive impairment. The resident received an antidepressant and antipsychotic on a routine basis, and had diagnoses which included Alzheimer's disease, insomnia, Parkinson's disease, and dementia with behaviors. Review of the 8/8/22 annual MDS assessment showed the resident received no psychological therapies by a licensed professional during the 7-day look-back period. Review of the 3/29/22 telehealth visit note showed the resident had depression present, had a good mood and calm behavior with no suicidal thoughts. Review of the care plan initiated on 9/12/21 showed interventions to "Follow-up with psychiatry as needed" and to monitor/document	F 740	1. When residents make suicidal threat staff will remain with the resident until the nurse supervisor/charge nurse is available to assess and evaluate the resident. 2. After assessing the resident the resident's physician and responsible party will be notified. 3. All staff will be notified caring for the resident to report any changes in behavior immediately. Updates to the care plan will be made accordingly until the physician has determine that the risk of suicide does not appear to be present. 4. Education on the facility policy titled "Suicide Threats" was done with all nursing staff on 4/27/2023, by the DON. 5. DON and RNs will monitor documentation for comments made by residents such as "I want to die," or "I wish I was dead" to ensure appropriate nursing assessments were complete and notifications to the resident's physician were made. DON and RNs will also ensure the resident was closely monitor for any changes in behavior.	

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F 740	Continued From page 15 and/or notify nurse of any changes in behaviors/mood. The following concerns were identified: a. Review of the 6/4/22 behavior note timed at 3:52 PM showed "When CNA had [him/her] on toilet [s/he] stated [s/he] didn't want to live anymore." b. Review of the 6/14/22 behavior note timed at 5:45 PM showed staff had reported the resident stated "I want to die", and when staff asked why, the resident stated s/he was"depressed". c. Review of the 6/17/22 at 5:29 PM health status note showed "While [s/he] did not call out for help repeatedly, [s/he] did inform [CNA name] that [s/he] "wished [s/he] was dead" as [s/he] was placed in [his/her] recliner this morning after breakfast". Further review of the medical record showed no evidence the facility notified the responsible party or physician for further direction. b. Interview with the DON on 4/13/23 at 11:47 AM revealed the resident often made these statements and confirmed the facility had not appropriately addressed the resident's suicidal ideations. 2. Review of the facility policy titled "Suicide Threats" which expired in 7/2022 showed the following: "3. A staff member shall remain with the resident until the Nurse Supervisor/ Charge Nurse arrives to evaluate the resident. 4. After assessing the resident in more detail, the Nurse Supervisor/ Charge Nurse shall notify the resident's Attending Physician and responsible party, and shall seek further direction from the physician. 5. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to	F 740	6. All deviations from this standard of practice noted in the policy will be tracked by the DON and/or designee and reported monthly at QA. 7. Resident #27 was assessed by psychiatrist and was noted to have no suicidal thoughts. DON also assessed resident #27 and was found to have no suicidal thoughts. 8. An audit was done of daily notes by DON, Social Worker and MDS coordinator to look for additional residents at risk.	

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F 740	Continued From page 16 report changes in the resident's behavior immediately. 6. As indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. 7. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present."	F 740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		5/2/23

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F 755	Continued From page 17 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review and facility policy review, the facility failed to administer medications as ordered by the prescriber for 1 out of 5 residents (#8) reviewed for medication administration. The findings were: 1. Review of the 3/13/23 annual MDS assessment showed resident #8 was admitted on 4/5/22 with adequate vision and used corrective lenses. Review of the most current physician orders showed the resident had an order for Refresh Plus Solution 0.5 % (active ingredient of carboxymethylcellulose sodium) eye drops every morning for dry eyes. The following concerns were identified: a. Observation on 4/12/23 at 7:36 AM showed the resident sitting in the dining room, when LPN #1 administered one drop of "dry eye relief" (active ingredients: glycerin, hypromellose and polyethylene glycol) eye drop solution to both eyes, and stated it was the only drops the resident received. b. Interview with LPN #1 on 4/12/23 at 2:50 PM revealed the facility was using eye relief drops provided from the pharmacy house stock. c. Interview on 4/12/23 at 3:03 PM with the pharmacy consultant confirmed nurses were expected to give the eye drops that had the same ingredients as the eye drops prescribed by the physician. d. Interview on 4/12/23 at 3:55 PM with the DON confirmed the expectation that medication	F 755	1. Eye drops for Resident #8 were switched out on 4/12/2023 with the eye drops containing the correct ingredients per the physicians prescription, by the pharmacy consultant. 2. Pharmacist reviewed all the medications on the cart that had been dispensed to the long term care unit and verified they were correct on 4/12/2023. 3. Pharmacy will review all dispensed meds at the time the medications are released to the long-term care unit. 4. Nursing will verify each medication given to the resident matches the order written by the provider "Right Drug", on the medication administration record, prior to the administration of the medication. 5. Education was done with nursing staff on 4/27/2023 by DON 6. Medications administered will be monitored weekly by pharmacists and DON or designee. 7. Medication errors will be reported in ActionCue and review monthly at QA.	

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F 755	Continued From page 18 administration was to follow the physician's order. 2. Review of the facility policy titled "Medication Administration" with an expiration date of 2/2024, showed "Nurses will administer medications safely to all residents in accordance with physician's orders. 2. Right drug. B. Each medication will be checked against the medication administration record (MAR) for the 6 R's (not documentation), prior to administration of any medication."	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		5/1/23

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F 758	Continued From page 19 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure appropriate behavior monitoring and interventions were in place for 1 of 5 sample residents (#3) reviewed for psychotropic medication use. The findings were: 1. Review of the 11/27/22 MDS assessment showed resident #3 was admitted on 11/15/22 and had a BIMS score of 2 out of 15 (severe cognitive impairment). The resident exhibited physical behaviors directed toward others 1 to 3 days of the 7-day look-back period; verbal behaviors directed toward others every day of the look-back period; and other behavioral symptoms	F 758	1. Resident #3 has "observe for behavior:" documented on the MAR for April in relation to quetiapine. 2. Resident #3 will have attempted non-pharmacological interventions documented. 3. An audit of all residents taking psychotropic drugs was completed by DON and phamarcist to ensure "observe for behavior" was documented on the MAR and that attempted non-pharmacological interventions are documented. 4. All Residents prescribed psychotropic drugs will have documented observed	

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F 758	Continued From page 20 not directed toward others 1 to 3 days of the 7-day look-back period. These behaviors put the resident at risk for physical illness or injury, interfered with care and social interactions, and put other residents at risk for physical injury. In addition, the resident rejected care 4 to 6 days of the 7-day look-back period. Further review showed the resident received an antipsychotic medication on 7 days of the 7-day look-back period. Review of a physician progress note, dated 11/29/22, showed the resident was agitated and physically aggressive "only when cares being provided" and had diagnoses which included Alzheimer's disease and unspecified dementia with other behavioral disturbance. Review of the current physician orders showed 25 milligrams of quetiapine (antipsychotic medication) was to be given twice a day with breakfast and lunch and 50 milligrams with dinner. Interview with CNA #1 on 4/12/23 at 9:05 AM revealed the resident only exhibited behaviors when personal cares were being performed; however, the behaviors were improving due to a new medication the resident had started to treat his/her diarrhea. In addition, the CNA stated she distracted the resident by asking about his/her children or animals which helped with behaviors during cares. The following concerns were identified: a. Review of the April 2023 MAR showed the facility was to "Observe for Behavior: (Specify)" and document if the resident was having behavior. In addition the facility was to document attempted non-pharmacological interventions. There was no evidence medication-specific target symptoms or non-pharmacological interventions had been identified. b. Review of the "Psychosocial Well-Being" care plan developed on 11/28/22 showed the resident was often physically and verbally	F 758	behaviors in their clinical recorded with documented non-pharmacological interventions. Education was done at the nursing staff meeting on 4/27/2023 by DON. 5. Clinical records of residents on psychotropic drugs will be monitored by pharmacist for appropirate clinical diagnois, when ordered received from the physician, and verifiy it is documented in the clinical record. 6. Documentation of observed behaviors and non-pharmacological interventions will be documented by nursing staff and monitored by DON and/or designee. 7. Documentation compliance will be reported monthly at QA	

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F 758	Continued From page 21 aggressive with personal cares, would reject care at times, and would frequently wander. Interventions included administer medications as ordered by the physician, explain to the resident cares as they were occurring, walking, napping, and redirecting as necessary. c. Interview with the DON on 4/12/23 at 9:56 AM confirmed resident-specific target behaviors and non-pharmacological interventions had not been defined.	F 758		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.	F 888		5/1/23

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F 888	Continued From page 22 §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely	F 888		

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F 888	Continued From page 23 documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to,	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535023	A. BUILDING _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTON COUNTY HEALTH SERVICES	**1124 WASHINGTON BLVD NEWCASTLE, WY 82701**

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F 888	Continued From page 24 individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on review of staff vaccination records, staff interview, and review of policy and procedure, the facility failed to ensure the development and implementation of additional precautions designed to mitigate the transmission and spread of COVID-19 for all staff who were not fully vaccinated for COVID-19. The census was 39. The findings were: 1. Review of the facility's vaccination records showed 42 employees and 1 volunteer were granted exemptions to the COVID-19 vaccination requirements. The following concerns were identified: a. Review of the policy and procedure titled "COVID-19 Vaccine and Healthcare Personnel", last revised 9/2022, showed the policy failed to include additional precautions for staff and volunteers who were not fully vaccinated. In addition, the policy failed to indicate what action	F 888	1. Policy was updated on 4/12/2023 to state that all exempt employees working in Long-term care would be testing weekly. 2. All employees working in long-term care with Covid-19 vaccine exemptions were tested for Covid-19 on 4/13/2023 3. Exempt employees were educated on 4/13/2023 by Infection Prevention RN. 3. Employees working in long-term care with a Covid-19 vaccine exemption will be tested weekly by the employee heatlh nurse or designee. 4. Monitoring will be done by the DON and reported monthly at QA.	

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F 888	Continued From page 25 would be taken for new employees that did not receive the second dose of the primary vaccine series, if applicable, 30 days after receiving the first dose. b. Interview with the infection preventionist (IP) on 4/11/23 at 3:44 PM revealed the facility required all staff and volunteers to take their temperature and self-screen for symptoms prior to having contact with residents. Further, the IP stated the facility had revised the policy in September of 2022 and it did not include the additional precautions as were outlined in the discontinued policy.	F 888		