STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

(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 7/24/23 to 7/27/23. Also reviewed in the course of the survey was complaint intake WY00003638. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing ADON: Assistant Director of Nursing SSD: Social Services Director MDS: Minimum Data Set med tech: Medical Technologist RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	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	F 600		

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

Electronically Signed | 08/18/2023

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, medical record review, facility incident investigation review, facility performance improvement plan review, and policy and procedure review, the facility failed to protect the resident's right to be free from sexual abuse by a resident for 1 of 3 sample residents (#43). This failure resulted in harm to resident #43 who experienced sexual abuse a reasonable person would have found humiliating, intimidating, demeaning, and degrading. The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 7/19/23. The findings were: 1. Review of the quarterly MDS assessment dated 4/26/23 showed resident #43 had short-term and long-term memory problems and diagnoses which included Alzheimer's disease, cerebrovascular accident, transient ischemic attack or stroke, and non-Alzheimer's dementia. Further review showed the resident required extensive physical assistance of 1 person for bed mobility, transfers, dressing, toilet use, locomotion on and off the unit, and personal hygiene. Review of the care plan showed a new focus was initiated on 7/17/23 titled "Resident experienced traumatic event." The following concerns were identified: a. Review of a progress note for resident #43 dated 7/17/23 and timed 9:49 AM showed the nurse found resident #44 standing at resident #43's bedside, undressed, with his/her hand in resident #43's brief. Resident #44 believed resident #43 was his/her spouse. The nurse removed resident #44 from the room and	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 2	F 600		

assessed resident #43's genitals. The nurse did not identify any injuries or abnormalities and the resident did not report any pain at that time; however, the resident showed symptoms of pain following the incident which resulted in transfer to the hospital.

b. Review of an "Alleged Abuse Report" for resident #43 dated 7/17/23 and timed 6:10 AM showed the nurse found resident #44 undressed at the bedside of resident #43. Resident #44 had his/her right hand under resident #43's brief and believed resident #43 was his/her spouse. Resident #44 was removed from the room and resident #43 was assessed for injuries. Further review showed resident #43 was assessed as having a pain score of 4 due to signs and symptoms of pain based on negative vocalization, facial expression, body language and consolability. The resident was sent to the hospital for evaluation.

c. Review of a hospital record for resident #43 dated 7/17/23 and timed 8:54 AM showed "Found this AM by nursing staff at [facility name] with undressed [female/male] who had hand down into [his/her] brief. No witnessed [genital to genital] contact. Pt states that [s/he] is unsure of what occurred this AM or why [s/he] is being seen in ER now. Denies pain or injury during external genitalia exam. Redness noted in abdominal fold-photograph taken. Pt confused at baseline."

d. Interview with RN #1 on 7/26/23 at 2:02 PM revealed resident #44 had dementia with short-term memory loss and a new diagnosis of urinary tract infection (UTI) which elevated his/her confusion at the time of the incident. The RN revealed prior to the incident, resident #44 had shown aggression towards staff, which included making threats, cursing, and physical behaviors; however, the resident had never directed any

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F 600	Continued From page 3	F 600		

behaviors toward other residents. The RN revealed the day of the incident was the first time he had observed resident #44 wander into other rooms and when he found the resident in the room of resident #43, resident #44 was completely undressed standing next to the bed of resident #43. The RN revealed resident #43's brief was not attached on the right side and resident #44 had his/her hand in the brief; however, the RN could not see what resident #44 was doing with his/her hand. The RN revealed resident #43 remained asleep during the encounter and resident #44 became aggressive when the staff member attempted to remove him/her from the room. The RN revealed resident #44 was provided a 1 to 1 staff member and resident #43 was assessed for injuries. Further interview revealed he did not identify any injuries to resident #43.

e. Interview with the social services director on 7/26/23 at 11:27 AM revealed the resident representative for resident #43 had visited the facility that day and did not want to be interviewed related to the incident. Further interview revealed the representative was happy with the resident's care and did not feel the resident was unsafe at the facility.

f. Review of a discharge summary note for resident #44 dated 7/17/23 and timed 12:51 PM showed the resident discharged from the facility to home with his/her spouse.

g. Interview with the resident representative for resident #44 on 7/26/23 at 5:29 PM confirmed the resident discharged from the facility on 7/17/23 after the incident.

h. Interview with the administrator, DON, ADON/infection preventionist, SSD, and regional resource nurse on 7/27/23 at 9:37 AM confirmed resident #43 was asleep in bed at the time of the

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F 600	Continued From page 4	F 600		

incident with resident #44. The interview revealed resident #44 had behaviors which included using foul language, yelling, and wandering and interventions were different with each behavioral display. Further interview confirmed a reasonable person who was cognitively intact may have been fearful of resident #44 in a similar situation.

2. Review of the policy titled "Abuse and Neglect Prohibition" last revised July 2018, showed "...Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms...Sexual abuse is non-consensual (the resident does not consent) sexual contact of any type with a resident. It may include, but is not limited to, sexual harassment, sexual coercion, and sexual assault..."

3. Review of the facility's performance improvement plan of correction dated 7/17/23 showed corrective action included immediate separation of the residents, assessment, first aid, and hospital transfer for evaluation and treatment for resident #43, implementation of 1 to 1 staffing for resident #44 until the resident's risk for unprovoked sexual behavior was addressed or the resident was discharged from the facility.

The facility contacted the physician, resident representative, ombudsman, and law enforcement, updated the care plans for both residents, and initiated social services 1 to 1 visits at least 3 times weekly for 1 month for resident #43.

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F 600	Continued From page 5 The facility reported the incident to the state survey agency and initiated an abuse investigation which included staff and resident interviews. The facility's plan showed all residents were potentially at risk and interviewed all residents, to identify additional incidents or allegations. Further the facility reviewed all skin assessments of incidents/accidents for the prior 30 days. The facility's plan showed system changes included reeducation of all staff on abuse, behavior management, and working with residents with behaviors to decrease risk of aggression and sexually acting out toward other residents. The facility's plan showed monitoring was initiated by reviewing the incident reporting system, reviewing the grievance management system, conducting resident and family interviews, and ombudsman feedback. The facility initiated a review of incident/accident documentation on residents residing at the facility 3 times weekly, decreasing to weekly for 1 month, and then as needed. The facility's plan showed on the spot education will be performed for all staff members present during an incident and counseling will be provided as indicated. The facility's plan showed any issues identified will be trended and reviewed in the facility's QAPI meeting to ensure the plan was implemented, sustained, and evaluated. The facility was determined to be in substantial compliance as of 7/19/23.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		8/24/23

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F 609	Continued From page 6 §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 medical record review, State Survey Agency incident report log review, policy review, and staff interview, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of the reasonable suspicion of a crime in accordance with Section 1150B of the Act for 1 of 3 sample residents (#9) reviewed for allegations of abuse. The findings	F 609	F609 Abuse Reporting Corrective Action: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	

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F 609	Continued From page 7 were: 1. Review of the facility's policy "Abuse & Neglect Prohibition", last revised July 2018, showed "...Reporting and Response 1. STATE REPORTING OBLIGATIONS: The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency, and law enforcement officials and adult protective services (where state law provides for jurisdiction in long-term care facilities) in accordance with Federal and State law through established procedures. Timeline for reporting is as follows: a. If the events that caused the allegation involve abuse or result in serious bodily injury, a report is made not later than 2 hours after the facility is notified of the allegation...5. The facility will submit a summary of its investigation to the appropriate State agency within 5 days of its initial report or within whatever time frame required by the State agency." The following concerns were identified: a. Review of a nurse's note dated 4/27/23 and timed 4:40 PM showed the power of attorney for resident #9 and the police department had been notified of an allegation of abuse which involved the resident and CNA #1; however, review of the state survey agency incident report logs showed this allegation was not reported to the agency until 4/28/23 at 5:23 PM. In addition, the summary of the facility's investigation was not reported to the agency until 5/16/23. 2. Interview with the DON, and the regional resource nurse on 7/25/23 at 1:05 PM confirmed the allegation of abuse was not reported within	F 609	correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. The facility will 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 in accordance with State law through established procedures. The facility reported the allegation by resident # 9 on April 28th. Identification: The facility currently has 57 residents who could be impacted. Systemic Changes: The facility policy and procedure and Regulatory requirements for Abuse reporting was reviewed. All staff will be provided re-education related to the facility policy and procedure for Abuse reporting, investigation, and appropriate corrective action, on 07/19/2023, by the	

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F 609	Continued From page 8 the required timeframe.	F 609	ED/DON. Monitoring: The ED/Designee will audit 100% of grievances and/or allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, weekly, for three months. The community reviewed the last 30 days of incidents, accidents, and grievances and not other abuse was identified. Audits will demonstrate compliance with the regulatory requirement and facility policy and procedure for Abuse reporting, investigation and appropriate corrective action. Audit results will be reviewed by the ED/Designee and areas of non-compliance will be addressed at the time they are identified. Audit trends will be reported to the facility QAPI committee monthly, for review and further corrective action when negative trends are identified. The ED/Designee will be delegated responsibility for assuring compliance with this plan of correction for F609. Compliance Date: 08/24/2023	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		8/24/23

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F 756	Continued From page 9 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure pharmacist recommendations were addressed by the attending physician for 1 of 5 sample residents (#8) reviewed for medications. The findings were: 1. Review of the 1/3/23 pharmacist consultation	F 756	F 756 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	

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F 756	Continued From page 10 report showed resident #8 received "an antipsychotic, Aripiprazole, for a potentially inappropriate indication: currently listed for "DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY" The pharmacist's recommendation was to "...review and consider updating indication vs. an attempt at a gradual dose reduction, with the end goal of discontinuation." The following concerns were identified: a. Review of the physician's response dated 1/11/23 showed he had declined the pharmacist's recommendation due to "Started by another provider." b. Review of the pharmacist's recommendation, dated 3/3/23, showed "REPEATED RECOMMENDATION from 1/3/2023: Please respond promptly to assure facility compliance with Federal regulations." Review of the medical record showed no evidence the physician had responded to the recommendation. c. Review of the pharmacist's recommendation, dated 4/5/23, showed "REPEATED RECOMMENDATION from 1/3/2023: Please respond promptly to assure facility compliance with Federal regulation." Review of the medical record showed no evidence the physician had responded to the recommendation. d. Review of the July 2023 medication administration record showed the resident received 2 milligrams of aripiprazole by mouth one time a day "related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, UNSPECIFIED SEVERITY, WITHOUT	F 756	correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. Corrective Action: DON or designee will review pharmacy recommendations each month and ensure follow through. The Arpiprazole was reduced on 8/15/23 and diagnosis was updated for Resident #8 Identification: Residents that reside at the facility may be subject to this deficiency. Systemic Changes: Pharmacist recommendations will be printed and faxed to physicians upon receipt and Nursing will follow up on Clinical Pharmacy recommendation. Completed Pharmacy Physician recommendations will be scanned into Medical records and hard copies of physician recommendation□s and Clinical Nursing recommendations will be filed in Notebook kept in DON/Designees office. ED/designee will provide education to	

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F 756	Continued From page 11 BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY" with a start date of 12/17/2022. 2. Interview with the regional resource nurse, SSD, DON, and ADON/infection preventionist on 7/26/23 at 5:20 PM confirmed the pharmacist's recommendation had not been addressed. 3. Review of the "LTC [long term care] Facility's Pharmacy Services and Procedures Manual", last revised 3/3/20, showed "...7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR [medication regimen review] and the Director of Nursing to act upon the recommendations contained in the MRR. 7.1 For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. 7.2 The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. 7.2.1 If the attending physician has decided to make no change in the medication, the attending physician should document the rationale in the residents' health record. 8. Facility should alert the Medical Director where MRRs are not addressed by the attending physician in a timely manner."	F 756	DON and DSD on drug regimen reviews, and the process on ensuring completion and follow up. Monitoring: Pharmacist recommendations will be monitored to ensure completion of recommendations monthly by the DON/designee. The NHA/Designee will monitor compliance monthly for 3 months and as needed at the facility monthly QAPI meeting. Date of Compliance: August 24, 2023	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		8/24/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 12 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a 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	F 758		

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	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

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F 758	Continued From page 13 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 medical record review and staff interview, the facility failed to ensure medication-specific target symptoms were identified and appropriate monitoring in place for 2 of 5 sample residents (#8, #9) reviewed for psychotropic medication use. The findings were: 1. Review of the quarterly MDS assessment dated 6/7/23 showed resident #8 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and diagnoses which included dementia, chronic pain, and age-related cognitive decline. Further review showed the resident received an antipsychotic and an antidepressant on 7 out of 7 days during the look-back period. Review of the physician orders showed the resident was prescribed aripiprazole (an antipsychotic) 2 milligrams (mg) by mouth one time a day related to dementia and duloxetine hydrochloride (an antidepressant) 60 mg delayed release capsule one time a day for pain. The following concerns were identified: a. Review of the resident's pain care plan, initiated on 9/27/22, showed the resident was prescribed an antidepressant for pain and the interventions included to monitor for side effects every shift by "using the behavior monitoring tool in the TAR [treatment administration record]." Review of the July 2023 TAR showed no evidence the side effects of the psychoactive	F 758	F 758 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. Corrective Action: On or before the allegation of compliance Nursing staff and IDT were educated on Unnecessary Medication policy to include policy and regulatory requirements for GDR reviews, Diagnosis, PRN Psychoactive stop dates, behavior documentation for medication use, non-pharmacological interventions prior to PRN medication use. Nurses that were not working during the education will be	

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F 758	Continued From page 14 medication were being monitored. b. Review of the medical record showed no evidence medication-specific target symptoms and side effects for the use of the antipsychotic medication had been identified and were being monitored. c. Interview with the DON on 7/26/23 at 5:17 PM confirmed the medical record lacked documentation of the monitoring for side effects of the antidepressant. In addition, the medical record lacked documentation of the identification of target symptoms and monitoring for the antipsychotic prescribed. 2. Review of the 6/7/23 quarterly MDS assessment showed resident #9 had a BIMS score of 5 out of 15, which indicated the resident had severe cognitive impairment, and had a diagnosis of depression. Review of the physician orders showed the resident was prescribed 150 mg extended release bupropion hydrochloride (antidepressant) one time a day every other day for depression with a start date of 6/25/23 and 10 mg of escitalopram oxalate (antidepressant) one time a day related to depression with a start date of 2/4/23. The following concerns were identified: a. Review of the medical record showed no evidence medication-specific target symptoms and side effects for each antidepressant prescribed had been identified and were being monitored. b. Interview with the DON and the regional resource nurse on 7/26/23 at 3:43 PM confirmed the medical record lacked documentation of the identification of medication-specific target symptoms and monitoring for each antidepressant prescribed.	F 758	educated 1:1 upon their return to work. Resident # 8 is prescribed Escitalopram for depression, and Bupropion for depression and the facility is currently tracking target behaviors. Resident # 9 is prescribed Aripiprazole for dementia with behavioral disturbance and the facility is currently tracking target behaviors. Identification: Residents currently receiving a psychotropic may be subject to this deficiency. A review of records for resident's receiving psychoactive medications will be conducted by the IDT Prior to the allegation of compliance to determine any Issues identified concerning appropriateness of behavioral tracking of target behaviors and identified Issues will be corrected at that time. Systemic changes: For residents who are prescribed psychoactive medications, the clinical record documentation needs to be reviewed to ensure: 1). Physician documentation includes; the physician's progress notes, history and physical, and orders to condition/Diagnosis as well as risks vs. benefit for prescribed medication if indicated. 2). Nursing/Clinical documentation includes; Interdisciplinary notes, care	

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F 758	Continued From page 15	F 758	plans and nursing notes that reflect the specific condition, appropriate Diagnosis, targeted behavior, and interventions and behavior monitoring when indicated. 3). Target behaviors, interventions, outcome and medication side effects are monitored daily for residents receiving anti psychotic, anti-anxiety, and sedative/hypnotic medications using the behavior monitoring form. 4). If a resident is prescribed a psychoactive medication, the Psychoactive Mediation Consent Form will be completed and signed by the resident and/or the resident's legal representative. 5) Gradual Dose reduction will be conducted in accordance to Regulatory guidelines unless contraindications are documented Nurses and IDT members will be educated on /or prior to the allegation of compliance. An attendance sheet was utilized at the education and all new staff will be educated upon hire as indicated. Monitor initiated. Monitoring: DON/Designee will audit records of residents with psychotropic medications monthly for 3 months then quarterly. Issues identified will be corrected at that time and on the spot reeducation will be done. The issues identified will be tracked/ trended for review by the QAPI committee for 3 months until compliance has been achieved. Date of compliance: August 24, 2023	

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F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.	F 801		8/24/23

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F 801	Continued From page 17	F 801		

(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically

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F 801	Continued From page 18 qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure the dietary manager met the required qualifications. The facility census was 53. The findings were: Interview with the dietary manager on 7/24/23 at 10:02 AM revealed she had been hired for the dietary manager position approximately "a month ago" and had enrolled in a certified dietary program in the past; however, she had not completed the course. Interview with the administrator and the dietary manager on 7/27/23 at 10:19 AM confirmed the facility did not have a qualified dietary manager or a full-time dietitian.	F 801	F801 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. CORRECTIVE ACTION: The dietary manager is currently enrolled in a CDM course. A qualified consultant nutritional professional is employed full-time by the community. IDENTIFICATION All residents that reside at the facility have the potential to be affected. SYSTEMIC CHANGES The Dietary manager is currently enrolled in the CDM Program with Dietitian oversite with the program. A qualified consultant nutritional professional is employed full-time by the community. The Community employs staff with appropriate competencies and skills sets to carry out the functions of the food and nutrition services taking into consideration resident	

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F 801	Continued From page 19	F 801	assessments, individual plans of care and the number, acuity, and diagnosis of facility resident population in accordance with the facility assessment. On or before the allegation of compliance the regional nurse consultant/ designee will in service ED, on ensuring there is a CDM and an RD in place. MONITORING The ED/Designee will monitor weekly to ensure the Dietary directors ongoing progress on the CDM certificate. The ED/Designee will monitor monthly to ensure RD is in place no less than 8 hours week. The NHA/designee with monitor the results of the audit in QAPI monthly committee meeting for 3 months and then as needed. DATE OF COMPLIANCE: 08/24/2023	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		8/24/23

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F 812	Continued From page 20 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, temperature log review, manufacturer instruction review, staff interview, and policy and procedure review, the facility failed to ensure the sanitization level of the automatic dishwasher was checked for 10 of 63 meals reviewed. In addition, the facility failed to ensure a sanitary environment during 2 of 2 kitchen observations and safe food temperatures during 1 of 1 meal preparation observations. The census was 53. The findings were: Related to monitoring of the dishwasher's chemical sanitizer concentration: 1. Review of the kitchen's temperature log worksheet showed the temperature of the wash and rinse water and the concentration of the chemical sanitizer was to be checked with each meal. The following concerns were identified: a. Review of the July 2023 temperature log sheets showed a sanitizer concentration of 0 ppm (parts per million) was recorded for the evening meal on 7/9/23 and 7/18/23. In addition a sanitizer concentration of 30 ppm was recorded for the evening meal on 7/16/23. There was no evidence the unacceptable ppm levels had been investigated. b. Review of the July 2023 temperature log sheets showed no documentation of the sanitizer or water temperatures were recorded for the morning and noon meals on 7/16/23; the evening meal on 7/17/23; the morning and noon meals on	F 812	F812 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. Correction: USE 2567 DETAILS 1- The milk identified in 2567 as being 44.8F was thrown away at time of survey. 2- The dish machine sanitizer solution is now maintained at the correct concentration. 3-cook #1 was in serviced immediately 07/27/2023 regarding professional food safety/service guidelines. 4- The pedestal fan was removed. 5-The oven mitts that cook #1 put her gloved hands in were discarded. 6-Dietary staff were educated on proper hand hygiene, and how to handle,	

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F 812	Continued From page 21 7/20/23; and the morning and noon meals on 7/22/23. 2. Interview with the registered dietitian on 7/26/23 at 2:41 PM confirmed the sanitization level of the dishwasher should be monitored. 3. Interview with the dietary manager and the administrator on 7/27/23 at 10:19 AM confirmed the sanitizer concentration level of the dishwasher was not monitored correctly. 4. Review of the "Dishwashing Machine Use" 2001 MED-PASS, Inc. (Revised March 2010) policy and procedure showed "Food service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation...6. Corrective action will be taken immediately if sanitizer concentrations are too low. 7. The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log...9. If hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or PPM are adjusted." The policy stated the concentration of the chlorine sanitizer should between 50 and 100 ppm. 5. Review of the 2022 U.S. Public Health Service Code showed "4-703.11 Hot Water and Chemical. (C) Chemical manual or mechanical operations, including the application of SANITIZING chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under § 4-501.114. Contact	F 812	prepare, or serve food to safe food handling and preparation to prevent any foodborne illness. 7-Cook #1 was re-educated on how to properly temp and serve various foods separately and document the finding. 8-Education was provided to all kitchen staff on how to properly temp and serve food after being mechanically modified Identification: Residents that reside at the facility have the potential to be affected by this alleged deficiency. Systemic Changes: On or before the date of compliance the Food Service Manager/Designee will in-service the dietary staff on food safety and sanitation including service temperatures to maintain food safety, Labeling and Dating per guidelines, ensuring the dish machine sanitation solution will be maintained to correct concentration food and kitchen equipment is cleaned and maintained. An attendance sheet will be kept. Monitoring: The Food Service Manager/Designee will complete weekly sanitation rounds for 2 months and then monthly and as needed to identify concerns regarding food storage and discard all food items out of temperature. The DON/Designee will complete weekly medication room rounds weekly for 2 months and then monthly for	

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F 812	Continued From page 22 times shall be consistent with those on EPA-registered label use instructions by providing: (1) Except as specified under Subparagraph (C)(2) of this section, a contact time of at least 10 seconds for a chlorine solution specified under 4-501.114(A), (2) A contact time of at least 7 seconds for a chlorine solution of 50 MG/L that has a PH of 10 or less and a temperature of at least 38oC (100oF) or a PH of 8 or less and a temperature of at least 24oC (75oF), (3) A contact time of at least 30 seconds for other chemical SANITIZING solutions, or (4) A contact time used in relationship with a combination of temperature, concentration, and PH that, when evaluated for efficacy, yields SANITIZATION as defined in 1-201.10(B). " 6. Review of the EcoLab ES-4000 dish machine manufacturer's instructions for use retrieved from http://manuals.jacksonmsc.com/ecolab%20manuals/ES-2000%20&%20ES-4000%20Rev%20O.pdf on 8/1/23 showed at a minimum water temperature of 120 degrees Fahrenheit was required with a recommended temperature of 140 degrees Fahrenheit and the minimum chlorine concentration was 50 ppm. Related to sanitary environment: 1. Observation on 7/26/23 at 9:27 AM showed cook #1 had donned gloves and was placing rolls on a pan with her gloved hands. At 9:35 AM the cook left the pan of rolls and opened the walk-in refrigerator door. The cook doffed her gloves and without performing hand hygiene donned new gloves then removed frozen soup from a container and placed it into a saucepan; turned on the faucet with her gloved hands, added water to the soup; covered the pan with aluminum foil,	F 812	2 months and then as needed to identify concerns regarding food storage, and refrigerator temperature monitoring. The NHA/Designee will monitor the results in QAPI monthly committee meeting for 3 months then as needed to ensure compliance. DATE OF COMPLIANCE: 08/24/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 23	F 812		

adjusted the heat on the stove, and placed the saucepan on the stove. With the same gloved hands the cook consulted the recipe book; entered the dry storage area and retrieved a box of scalloped potatoes; obtained a clean pan; sprayed the pan with cooking spray; and returned to the recipe book. The cook used her gloved hands to turn on the faucet to fill up a pitcher with water; entered the walk-in refrigerator and retrieved a cube of butter; obtained a knife and a cutting board; unwrapped the butter and touching the butter with her gloved hands cut off a section; rewrapped the butter and returned it to the walk-in refrigerator. The cook used scissors to open seasoning packets for the scalloped potatoes and added the contents of the packets to a pan on the stove; opened the oven door; adjusted the temperature knob; poured the dried potatoes from the box into the pan; donned oven mitts over the top of her gloved hands; again opened the oven door; removed the oven mitts and covered the saucepan with aluminum foil; donned the oven mitts over her gloved hands; and placed the pan into the oven. The cook removed the oven mitts and adjusted a knob on the oven. At this time the dietary manager donned the same oven mitts with her bare hands.

2. Observation at 11:44 AM showed cook #1 donned a pair of gloves; used a pen; donned oven mitts over her gloved hands and removed a pan of rolls from the oven; removed the oven mitts; obtained the temperature of the rolls; and used her gloved hands to pick up the rolls and place them in a serving pan. The cook placed her gloved hands into the oven mitts and retrieved a second pan of rolls from the oven; doffed the oven mitts; and transferred the rolls using her gloved hands to the serving pan. At this time the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

(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 812	Continued From page 24	F 812		

cook placed her gloved hands into the oven mitts and retrieved a pan of gravy off of the serving table; doffed the oven mitts; entered the dry storage area and obtained a new packet of gravy and proceeded to make the gravy. At 11:59 AM the cook doffed her gloves and performed hand hygiene.

3. Observation on 7/24/23 at 9:45 AM and again on 7/26/23 at 8:58 AM showed a pedestal fan that was darkened and soiled with debris was blowing air on the dishwashing racks which held clean dishes. Interview with dietary aide #1 on 7/26/23 at 9:01 AM revealed the fan was used to "help the dishes dry faster."

4. Interview with the registered dietitian on 7/26/23 at 2:41 PM confirmed a fan soiled with debris should not be blowing on clean dishes and acknowledged the facility needed more training in the area of hand hygiene.

5. Interview with the dietary manager and the administrator on 7/27/23 at 10:19 AM confirmed there was a need for education in regard to hand hygiene, and they had the pedestal fan removed from the kitchen.

6. Review of the "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" 2001 MED-PASS, Inc (Revised November 2022) showed "All employees who handle, prepare or serve food are trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents...6. Employees must wash their hands: ...c. whenever entering or re-entering the kitchen;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

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F 812	Continued From page 25	F 812		

d. before coming in contact with any food surfaces; e. after handling raw meat, poultry or fish and when switching between working with raw food and working with ready-to-eat food; f. after handling soiled equipment or utensils; g. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or h. after engaging in other activities that contaminate the hands."

7. Review of the 2022 U.S. Public Health Service Food Code showed 2-301.14 "2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking;
(E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD;
(H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

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F 812	Continued From page 26	F 812		

hands."

8. Review of the 2022 U.S. Public Health Service Food Code 4-601.11 showed "Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." and 4-903.11 "Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted."

Related to food temperature:

1. Observation on 7/26/23 at 11:44 AM showed cook #1 was checking the temperature of the unmodified foods which included soup, ham and potato casserole, scalloped potatoes, fish, carrots, and rolls which had been placed in the waterless hot food unit prior to the start of food service. However, the temperature of the fortified potatoes, gravy, and pureed carrots were not obtained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

(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 812	Continued From page 27 2. Observation on 7/26/23 at 12:12 PM showed cook #1 and the dietary manager became aware the texture of the main dish of ham and potato casserole had not been modified for the residents which required a pureed diet. The dietary manager obtained 7 portions of the ham and potato casserole from the waterless hot food unit and placed it into the Robot Coupe (food processor) with some hot water and thickening powder. After changing the consistency of the food, the dietary manager placed the pureed main course back onto the serving unit without checking the food's temperature. 3. Review of the 7/2/23 to 7/22/23 kitchen temperature log worksheets showed no evidence the temperature of mechanically-altered foods had been taken prior to service on any of the 21 days reviewed. 4. Interview with the registered dietitian on 7/26/23 at 2:41 PM confirmed the temperature of pureed foods should be monitored. 5. Interview with the dietary manager and the administrator on 7/27/23 at 10:19 AM confirmed the temperature of mechanically-altered food was not monitored. 6. Review of the "Food Preparation and Service" 2001 MED-PASS, Inc policy, last revised November 2022 showed "...11. Mechanically altered hot foods prepared for a modified consistency diet remain above 135 degrees F (Fahrenheit) during preparation or they are reheated to 165 degrees F for at least 15 seconds if holding for hot service."	F 812		

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	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

(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 812	Continued From page 28 7. Review of the 2022 U.S. Public Health Service Food Code showed 3-501.16 "Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5°C (41°F) or less."	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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	F 880		8/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

(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 29	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	503 S 18TH ST LARAMIE, WY 82070

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F 880	Continued From page 30 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection control techniques were utilized during 1 of 2 dining observations. The census was 53. The findings were: 1. Observation on 7/24/23 beginning at 12:16 PM showed CNA #3 approached resident #27 and touched the resident on his/her shoulder. The resident requested something to drink and the CNA walked across the dining room, obtained a cup of hot water and a packet of cocoa, opened the cocoa packet, and emptied the contents of the packet into the cup. The CNA took the empty packet to the trash receptacle, used his hand to push open the hinged door of the trash receptacle and discarded the empty packet. After placing a plastic spoon in the cup, the CNA began stirring the contents and delivered the cup to the resident. The CNA left the table and obtained a meal tray from the kitchen window and delivered the tray to resident #47. The CNA picked up the resident's utensils and cut the resident's food before handing the utensils to the resident. The CNA returned to the kitchen window, obtained another tray, and delivered it to resident #50. Before placing the tray on the resident's table, the CNA grabbed the resident's drinking glass by placing his fingers around the external rim, and moved it to the side. The CNA used the resident's utensils to cut his/her food before handing the utensils to the resident. Before leaving the table,	F 880	F880 Infection Prevention & Control Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1. CORRECTIVE ACTION The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. Educate C.N.A #3, reeducated on completing hand hygiene, moving between residents, touching residents while assisting with dining and touching potentially contaminated surfaces.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	503 S 18TH ST LARAMIE, WY 82070

(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 the CNA placed his hand on the handle of resident #50's wheelchair. The CNA returned to the kitchen window, obtained a meal tray, and delivered it to resident #40. The CNA removed the items from the tray, placed his hand on the back of resident #29, used resident #40's utensils to cut his/her meal, and handed the utensils to the resident. No hand hygiene was performed during the observation. 2. Interview with the infection preventionist/ADON on 7/27/23 at 12:54 PM revealed when serving meal trays, hand hygiene should be performed between trays or when staff contact other individuals or items to prevent cross contamination. 3. Review of the policy titled "Handwashing/Hand Hygiene" last revised August 2019 showed "...7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:...b. Before and after direct contact with residents...l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident...o. Before or after eating or handling food; p. Before and after assisting a resident with meals..."	F 880	2. IDENTIFICATION The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for: (1) Ensuring a hand hygiene program in accordance with current nursing facility guidelines from the Centers for Disease Control and Prevention (CDC). Observe any remaining staff to determine if staff practice timely hand hygiene, when indicated, in the dining room. Education will be provided for any observed deviations from expected practices. 3. SYSTEMIC CHANGES On or before August 25, 2023, the facility shall complete the following actions: The DON, SDC, IP or suitable designee will ensure the following: All nursing staff will receive education on keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents while assisting with Dining. 4. MONITORING Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	503 S 18TH ST LARAMIE, WY 82070

(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	implemented and effective. Such monitoring will include: Observations of staff to ensure timely hand hygiene, when indicated, in the course of assisting with dining Observations will be made during dining services. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance performance improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. CORRECTION DATE August 24, 2023	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		8/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

(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 883	Continued From page 33 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	503 S 18TH ST LARAMIE, WY 82070

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F 883	Continued From page 34 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure vaccinations were administered to 2 of 5 sample residents (#25, #42) reviewed for immunizations. The findings were: 1. Review of a "Resident Immunization Consent Form" dated 11/10/22 showed resident #25 accepted the pneumococcal vaccine; however, review of the medical record showed no evidence the pneumococcal vaccine was administered. 2. Review of a "Resident Immunization Consent Form" dated 4/2/22 showed resident #42 accepted the influenza vaccine; however, review of the resident's medical record showed no evidence the resident received the vaccination. 3. Interview with the infection preventionist/ADON, regional resource nurse, and DON on 7/27/23 at 12:51 PM revealed the facility was unable to find evidence the residents received the accepted vaccinations. 4. Review of the policy titled "Vaccinations of Residents" provided by the administrator on	F 883	F 883 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. CORRECTIVE ACTION On or before 08/25/2023, Resident #25 was offered the pneumococcal immunization along with request for physician orders. The Resident□s pneumococcal immunization record will be updated by licensed nursing staff upon administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	503 S 18TH ST LARAMIE, WY 82070

(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 883	Continued From page 35 7/27/23 showed "...All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated...3. All new residents shall be assessed for current vaccination status upon admission...6. If the resident receives a vaccine, at least the following information shall be documented in the resident's medical record: a. site of administration; b. Date of administration; c. Lot number of the vaccine (located on the vial); d. Expiration date (located on the vial; and e. Name of person administering the vaccine. 7. Certain vaccines (e.g., influenza and pneumococcal vaccines) may be administered per the physician-approved facility protocol (standing orders) after the resident has been assessed by the physician for medical contraindications for each vaccine. The resident's attending physician must provide a separate written order for any other vaccination, and such orders shall be recorded in the resident's medical record..."	F 883	On or before 08/25/2023, resident #42 was offered the influenza vaccine along with request for physician orders. This vaccine will be administered during the next flu clinic. The resident□s influenza immunization record will be updated by licensed nursing staff upon administration. IDENTIFICATION Residents that reside at the facility are at potential for risk. On or before the allegation of compliance the DON/ designee will review records for those residents currently residing at Cottonwood to identify if the influenza/pneumococcal, immunization was offered and/ or refusal is documented in Residents immunization records. For Residents identified as not having a pneumococcal vaccine/influenza vaccine the facility will offer the vaccine and/ or refusal will be documented in the resident□s medical record. SYSTEMIC CHANGES On or before date of compliance SDC/Designee will track and trend resident immunizations to ensure the resident was offered the vaccine and the outcome was properly documented in the resident□s immunization record. Beginning August 11, 2023 and continuing up until the allegation of compliance SDC/designee will educate licensed nursing staff on offering residents the immunization(s) on admission and prn and documentation of acceptance or refusal. At attendance sheet will be kept and reconciled with the active Nursing staff Roster and those RN□s/ LPN□s unable to attend will be provided 1:1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONWOOD HEALTH AND REHABILITATION	**503 S 18TH ST LARAMIE, WY 82070**

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F 883	Continued From page 36	F 883	education. MONITORING The SDC/Designee will do random audits 3 times weekly for 1 month, weekly for 1 month, monthly for 3 months and as needed to ensure that immunizations were offered and/ or refusal documented. SDC/Designee will track and trend residents to ensure immunizations have been offered to them. Any issues identified will be addressed at that time and issues identified will be reported to the monthly QAPI committee meeting to ensure the plan was implemented, sustained, and evaluated for its effectiveness. DATE OF COMPLIANCE □ August 24, 2023	