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	535040	A. BUILDING _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/27/23 through 8/30/23. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set PTA: Physical Therapy Assistant RN: Registered Nurse SNF: Skilled Nursing Facility Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		10/16/23

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

Electronically Signed | 09/20/2023

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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of beneficiary protection notice information, staff interview, and policy and	F 582	1. The facility will ensure that the Notice of Medicare Provider Non-Coverage	

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F 582	Continued From page 2 procedure review, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (NOMNC) and the Skilled Nursing Facility-Advanced Beneficiary Notice of Non-coverage (SNF-ABN) forms were issued to the resident or the resident's representative in a timely manner for 1 of 3 sample residents (#17) reviewed. The findings were: 1. Review of the SNF Beneficiary Protection Notification Review form completed by the facility showed resident #17 had a Medicare Part A stay that started on 12/27/22 with the last covered day of Part A services on 2/19/23. The following concerns were identified: a. Review of the NOMNC and SNF-ABN forms showed the resident's representative signed the forms on 3/6/23. b. Review of the facility's documentation showed the NOMNC and SNF-ABN forms were mailed to the resident's representative via certified mail on 3/1/23. There was no documentation the resident's representative had been contacted prior to the last day of Medicare Part A coverage. c. Interview with the social services director on 8/28/23 at 2:17 PM confirmed the required notices were not given to the resident or the resident's representative until after the resident was discharged from Medicare Part A. Further, the social worker stated she usually called the resident's representative if the resident was cognitively impaired prior to the end of Medicare Part A services; however, no documentation could be located. 2. Review of the policy and procedure titled "Advance Beneficiary Notices", last reviewed 6/2022, showed "...7. To ensure that the resident,	F 582	(NOMNC) and the skilled Nursing Facility-Advanced Beneficiary Notice of Non-coverage (SNF-ABN) forms are issued to the resident or the resident's representative in a timely manner. 2. Resident #17 representative was eventually notified, as noted above. 3. All residents and or representatives will have the NOMNC and SNF-ABN reviewed with them via phone call and mailed to them (if unable to hand deliver) at least two days prior to being discharged from a Medicare A or Medicare B stay. 4. Three other staff members have been educated and understand that if SS is out of the building it is their responsibility to ensure letters go out and calls are made. 5. An audit will be done on all residents who have been on Medicare A and or B in the last six months have had letter and calls done at least two days prior to being dc'd. 6. SS will be educated on the regulation and DCC's policy concerning the NOMNC and SNF-ABN. 7. SS or designee will do monthly audits on all dc's from Medicare A and Medicare B stays that the NOMNC and SNF-ABN is completed, phone call, hand deliver/mailed at least two days prior to DC. 8. The audit will be brought to QAPI for 90 days or until resolved.	

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F 582	Continued From page 3 or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending...10. d. If the notice cannot be hand-delivered (for example, such as in the case of an incompetent resident and the representative is out of town), a telephone notice shall be made, followed up immediately with a mailed, emailed, faxed or hand-delivered notice. Documentation shall comply with form instructions regarding telephone notices..."	F 582		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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-	F 604		10/16/23

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F 604	Continued From page 4 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure a restraint was the least restrictive alternative, used for the least amount of time, and failed to inform and obtain consent from the resident or the resident's representative for the use of the restraint for 1 of 2 sample residents (#31) with restraints. The findings were: 1. Review of the 7/12/23 admission MDS assessment showed resident #31 was admitted to the facility on 7/6/23 with diagnoses which included hip fracture and dementia. The resident was determined by staff assessment to be severely cognitively impaired and required the extensive assistance of two or more staff for transfers. In addition, the resident was coded as using a physical restraint in the resident's chair to prevent the resident from rising on a daily basis. Review of the 7/12/23 care area assessment (CAA) for physical restraints showed "resident has dementia and weight bearing restrictions. [S/he] does not remember [s/he] broke [his/her] hip and attempts to ambulate. Lap buddy while in wheelchair supervised in dining room." Further, the CAA stated the resident "can remove but not on request." Review of a 7/6/23 occupational	F 604	1. The facility will ensure that restraints are the least restrictive alternative, used for least amount of time, and will ensure to inform and obtain consent from the resident or the resident's representative for the use of a restraint. a. Resident #31 will be re-evaluated by PT to determine if he/she should still have the lap buddy. Resident #31's representative will be informed and DCC will obtain consent of the restraint (lap buddy). b. All residents will be evacuated if a restraint is the least restrictive alternative, used for the least amount of time and inform and obtain consent from the resident or the resident's representative for the use of the restraint. And will continue to be evaluated on a monthly basis while using the restraint. And documentation that less restrictive alternatives were attempted. c. All nursing staff, IDT, and therapy staff will be educated that DCC will ensure that restraints are the least restrictive alternative, used for least amount of time, and will ensure to inform and obtain consent from the resident or the resident's	

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F 604	Continued From page 5 therapist progress note showed a safety evaluation was completed for transfers, a wheelchair, a lap buddy, and a front-wheeled walker. The following concerns were identified: a. Observation on 8/28/23 at 4:45 PM showed the resident was sitting in a wheelchair in the secure unit with a Posey lap buddy (a device used to facilitate upper body alignment and prevent forward leaning) attached to the chair. The resident was self-propelling his/her wheelchair throughout the secure unit common room. b. Interview with CNA #1 on 8/17/23 at 4:41 PM revealed the resident had a lap buddy to keep the resident in his/her wheelchair when s/he was not weight bearing. c. Interview with the certified occupational therapy assistant (COTA) on 8/29/23 at 9 AM revealed the purpose of the lap buddy, at the time of admission, was to give staff time to get to the resident when the resident attempted to stand up. The COTA stated the resident was improving and liked to be ambulatory; however, the secure unit was "chaotic" and he did not feel comfortable allowing the resident to be ambulatory until the resident was discharged to the assisted living facility. In addition, the COTA stated the resident was able to remove the lap buddy; however, s/he was unable to do it on command. d. Review of the resident's "ADLs Functional Status/Rehabilitation Potential" care plan, dated 8/27/23, showed the resident had progressed and was able to self-propel his/her wheelchair and no longer wanted foot pedals on the wheelchair for easier movement. e. Review of the resident's medical record showed no documentation the resident's representative was informed of the potential risks and benefits of using the physical restraint. In	F 604	representative for the use of a restraint. And that when restraints are deemed the most appropriate, that they are re-evaluated on a monthly basis by therapies. And that other less restrictive alternatives were attempted and documented. d. Restorative or designee will audit all residents on a monthly basis that have restraints are deemed still appropriate to have and the resident and or representative have been informed and DCC obtains consent. e. The results of the audit will be brought to QAPI for 90 days or until resolved.	

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F 604	Continued From page 6	F 604		

addition, there was no documentation the facility had re-evaluated the need for the physical restraint.

f. Interview with the assistant administrator on 8/28/23 at 5:05 PM confirmed no further documentation was available.

2. Review of the policy and procedure "Restraint Free Environment", implemented on 6/25/23, showed "Definitions "Physical Restraint" refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to:...Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising...5. Before the resident is restrained, DCC [Douglas Care Center] will determine the presence of a specific medical symptom that would require the use of restraints, and determine: a. How the use of restraints would treat the medical symptom. b. The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released. c. The type of direct monitoring and supervision that will be provided during use of the restraint. d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place. e. How to assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. 6. Medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include

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F 604	Continued From page 7 documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint in treating the medical symptom. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint."	F 604		
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 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.	F 656		10/16/23

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F 656	Continued From page 8 (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 interview, medical record review, manufacturer recommendations, and policy and procedure review, the facility failed to develop and implement resident care plans related to pressure-relieving devices for 2 of 4 residents reviewed (#10, #14) for pressure injuries. The findings were: 1. Review of the quarterly MDS assessment dated 6/27/23 showed resident #10 had diagnoses which included hip fracture, obesity, and weakness, and was at risk for pressure ulcer development. Further review showed the resident required extensive physical assistance of 2 or more people for bed mobility and toilet use, extensive physical assistance of 1 person for dressing and personal hygiene, and transfers did not occur during the look-back period. Review of a "Wound Management Detail Report" showed on	F 656	1. The facility will ensure to develop and implement resident care plans related to pressure-relieving devices. a. Resident #10 had the multiple layers removed from underneath him/her, following the manufactures recommendations. Resident #10 had his/her care plan updated. b. All residents that have air mattress will have the multiple layers removed from their bed and DCC will follow the manufactures recommendations. All residents who have air mattresses have had their care plans audited to ensure that the residents preferences are being cp'd. c. Care conference checklist created to audit each resident with quarterly care plans. d. Recurrent education plan.	

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F 656	Continued From page 9 8/28/23 the resident had a stage 2 wound which measured 0.2 centimeters (cm) by 0.3 cm which was "very superficial." Further review showed the wound was identified on 8/21/23. The following concerns were identified: a. Observation on 8/29/23 beginning at 4:38 PM showed CNA #2 and CNA #3 entered the resident's room to answer the call light. At that time, the resident requested a bed pan and the CNAs assisted the resident to roll to his/her left side. Continued observation showed the resident had several layers of items which included an incontinence brief, a disposable incontinence pad, a flat sheet folded in half, and a fitted sheet between the resident and the air mattress. b. Observation on 8/30/23 at 11:06 AM showed RN #1, the infection preventionist, and LPN #1 entered the resident's room to perform wound care. The staff members positioned the resident on his/her left side and the resident's catheter drainage bag was secured to the right side of the bed. Continued observation showed the resident had several layers of items, which included an incontinence brief, a disposable incontinence pad, a flat sheet folded in half which created 2 layers, and a fitted sheet, between the resident and the air mattress. RN #1 removed the dressing to the resident's buttocks and the skin appeared red in color with no visible open area. Upon completion, the staff members positioned the resident on his/her back with the head of the bed slightly elevated and placed a pillow under the resident's right arm. All layers were left under the resident. c. Review of the "Skin Integrity/Pressure Ulcer" care plan, last revised on 8/21/23, showed the resident was at risk for skin breakdown and had interventions which included "my staff got be [sic] an alternating air flow mattress due to my	F 656	e. Add to annual competency checks for all nursing. f. All nursing staff will be educated on manufactures guidance on number of layers and what should be used on the mattress. g. Restorative or designee will audit that #10 and all other residents do not have multiple layers and that we are following manufactures recommendations on a monthly basis. h. The audit results will be brought to QAPI for 90 days or until resolved. 2. Resident #14 had the multiple layers removed from underneath him/her, following the manufactures recommendations. a. Resident #14 will be care planned that he/she requests a sheepskin be placed under him/her. a. All residents that have air mattress will have the multiple layers removed from their bed and DCC will follow the manufactures recommendations. b. All nursing staff will be educated on manufactures guidance on number of layers and what should be used on the air mattress. c. Restorative or designee will audit that #14 and any other residents with air mattresses do not have multiple layers and that we are following manufactures recommendations on a monthly basis. d. The audit results will be brought to QAPI for 90 days or until resolved.	

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limited mobility with my femur fracture." There was no indication how to use the air mattress per manufacturer's recommendations or the use of multiple layers under the resident while in bed.

2. Review of the quarterly MDS assessment dated 7/28/23 showed resident #14 had diagnoses which included a stage 2 pressure ulcer of the right hip, morbid obesity, unilateral primary osteoarthritis affecting the left knee, a body mass index of 70 or greater, and was at risk for pressure ulcer development with one stage 2 pressure ulcer present. Further review showed the resident required extensive physical assistance of 2 or more people for bed mobility, toilet use, and personal hygiene and transfers did not occur during the look-back period. The following concerns were identified:

a. Observation on 8/28/23 beginning at 2:41 PM showed PTA #1, RN #1, CNA #4, and the wound care nurse entered the resident's room to perform wound care. The staff members assisted the resident to roll to his/her right side which exposed multiple layers which included an incontinence brief, a disposable incontinence pad, and a sheepskin pad between the resident and the air mattress. Upon completion, the staff members positioned the resident on his/her back with the head of the bed slightly elevated and a wedge cushion under the resident's upper body. All layers were left under the resident.

b. Review of the "Skin Integrity/Pressure Ulcer" care plan last revised on 8/21/23 showed the resident was at risk for skin breakdown due to his/her weight, incontinence, and lack of mobility. Further review showed interventions which included "my new air bed arrived and is placed on my bed as of 11/24/22;" however, there was no indication how to use the air mattress per

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F 656	Continued From page 11	F 656		

manufacturer's recommendations or the use of multiple layers under the resident while in bed.

3. Interview with the wound care nurse on 8/30/23 at 9:23 AM revealed residents should only have a brief, incontinence pad, and sheet under them if they are at risk for skin breakdown and use an air mattress. Further interview revealed, if the resident had a Foley catheter in place the resident should only have 1 layer between them and the air mattress, especially if the resident was able to call for a bed pan. Further interview revealed resident #14 had requested the sheepskin to be under him/her and resident requests for additional layers should be included on the care plan.

4. Telephone interview with the DON on 8/30/23 at 9:49 AM revealed resident repositioning was expected to be performed every 2 to 4 hours depending on the care plan and residents with an air mattress should only have a sheet and pad specific for the air mattress (incontinence pad/barrier pad) under them. The DON confirmed resident requests for additional layers should be on the care plan and revealed if the resident had actual wounds staff should follow the wound care team recommendations.

5. Review of the manufacturer's recommendations titled "PressureGuard Bariatric APM [Alternating Pressure Mattress]" provided by the facility on 8/30/23 showed "...Bed Linens: Seven-inch deep fitted sheets are recommended. Multiple layers of linens or underpads beneath the patient should be avoided for the prevention and treatment of pressure injuries."

6. Review of the policy titled "Pressure Injury

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F 656	Continued From page 12 Prevention guidelines" dated 6/26/23 showed "...5. Prevention devices will be utilized in accordance with manufacturer's recommendations (e.g., heel flotation devices, cushions, mattresses)..."	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 661		10/16/23

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F 661	Continued From page 13 Based on medical record review, staff interview, and policy and procedure review, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay for 1 of 1 resident (#42) reviewed for discharge to the community. The findings were: 1. Review of the medical record for resident #42 showed s/he was admitted to the facility on 4/25/23 for rehabilitation following a cerebral vascular accident. The resident was discharged to the community on 7/18/23. Further review of the resident's medical record showed no evidence a discharge summary had been completed. Telephone interview with the DON on 8/30/23 at 9:50 AM confirmed the discharge summary had not been completed. 2. Review of the "Transfer and Discharge (including AMA)" policy implemented on 7/18/23 showed "...14. b. A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nursing department at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. ii. A final summary of the resident's status. iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment..."	F 661	1. The facility will ensure to complete a discharge summary which includes a recapitulation of the resident's stay. 2. Resident #42 will have recapitulation of stay completed. 3. All residents who are discharged will have a discharge summary done at the time of discharge. 4. An audit of all residents who have been dc'd in the last month will be done. 5. Clarification of who is responsible for doing discharge summary, so there is no confusion as to who is supposed to do ti. 6. IDT care plan team and MDS nurse will be educated that discharge summaries are done prior to residents being discharged. The education will include a recap of the residents stay that includes diagnoses, course of illness/treatment or therapy and pertinent lab, radiology and consultation results final summary of the resident's status and reconciliation of the pre-discharge medication with the resident's prost discharge medication; a post discharge plan of care that is developed with the participation of the residents and the resident's representatives which will assist the resident to adjust to his/her new living environment. 7. SS or designee will do an audit of all discharged residents going forward to ensure that complete discharge summaries are done prior to discharge. 8. The audit results will be brought to QAPI for 90 days or until resolved.	

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F 686	Continued From page 14	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, manufacturer recommendations, and policy and procedure review, the facility failed to ensure pressure-relieving devices to prevent pressure injuries or deterioration of pressure injuries were used appropriately for 2 of 4 residents reviewed (#10, #14) for pressure injuries. The findings were: 1. Review of the quarterly MDS assessment dated 6/27/23 showed resident #10 had diagnoses which included hip fracture, obesity, and weakness, and was at risk for pressure ulcer development. Further review showed the resident required extensive physical assistance of 2 or more people for bed mobility and toilet use, extensive physical assistance of 1 person for dressing and personal hygiene, and transfers did not occur during the look-back period. Review of a "Wound Management Detail Report" showed on	F 686	1. The facility will ensure pressure-relieving devices to prevent pressure injuries or deterioration of pressure injuries are used appropriately. 2. Residents #10 and 14 have had all extra items that are not recommended by the manufactures recommendations removed. 3. All residents that have air mattress will have the multiple layers removed from their bed and DCC will follow the manufactures recommendations. 4. All nursing staff will be educated on manufactures guidance on number of layers and what should be used on the mattress. 5. Restorative or designee will audit that resident #10, #14 and all other residents do not have multiple layers and that we are following manufactures	10/16/23

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F 686	Continued From page 15 8/28/23 the resident had a stage 2 wound which measured 0.2 centimeters (cm) by 0.3 cm which was "very superficial." Further review showed the wound was identified on 8/21/23. Review of the "Skin Integrity/Pressure Ulcer" care plan, last revised on 8/21/23, showed the resident was at risk for skin breakdown and had interventions which included "My staff will assist me to reposition as I allow every 2-3 hours" and "My staff got be [sic] an alternating air flow mattress due to my limited mobility with my femur fracture." The following concerns were identified: a. Observation on 8/29/23 at 4:38 PM showed the resident was in bed with the head of the bed slightly elevated, lying on his/her back and a catheter drainage bag was secured to the side of the bed when CNA #2 and CNA #3 entered the resident's room to answer the call light. The resident requested a bed pan and the CNAs assisted the resident to roll to his/her left side. Continued observation showed the resident had several layers of items which included an incontinence brief, a disposable incontinence pad, a flat sheet folded in half which created 2 layers, and a fitted sheet, between the resident and the air mattress. b. Observation on 8/29/23 at 11:06 AM showed RN #1, the infection preventionist, and LPN # 1 entered the resident's room to perform wound care. The staff members positioned the resident on his/her left side and the resident's catheter drainage bag was secured to the right side of the bed. Continued observation showed the resident had several layers of items, which included an incontinence brief, a disposable incontinence pad, a flat sheet folded in half which created 2 layers, and a fitted sheet, between the resident and the air mattress. RN #1 removed the dressing to resident's buttocks and the skin	F 686	recommendations on a monthly basis. 6. The audit results will be brought to QAPI for 90 days or until resolved.	

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F 686	Continued From page 16	F 686		

appeared red in color with no visible open area. Upon completion, the staff members positioned the resident on his/her back with the head of the bed slightly elevated and placed a pillow under the resident's right arm. All layers were left under the resident.

2. Review of the quarterly MDS assessment dated 7/28/23 showed resident #14 had diagnoses which included a stage 2 pressure ulcer of the right hip, morbid obesity, unilateral primary osteoarthritis affecting the left knee, and a body mass index of 70 or greater, and was at risk for pressure ulcer development with one stage 2 pressure ulcer present. Further review showed the resident required extensive physical assistance of 2 or more people for bed mobility, toilet use, and personal hygiene and transfers did not occur during the look-back period. Review of the "Skin Integrity/Pressure Ulcer" care plan last revised on 8/21/23 showed the resident was at risk for skin breakdown due to his/her weight, incontinence, and lack of mobility. Further review showed interventions which included "my new air bed arrived and is placed on my bed as of 11/24/22" and due to the resident's fragile skin s/he had developed 2 new wounds as of 8/21/23. The following concerns were identified:

a. Observation on 8/28/23 at 2:41 PM showed the resident was lying in bed, on his/her back, with the head of the bed slightly elevated and a wedge cushion under the resident's upper body when PTA #1, RN #1, CNA #4, and the wound care nurse entered the resident's room to perform wound care. The staff members assisted the resident to roll to his/her right side which exposed multiple layers which included an incontinence brief, a disposable incontinence pad, and a sheepskin pad between the resident

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F 686	Continued From page 17	F 686		

and the air mattress. Upon completion, the staff members positioned the resident on his/her back with the head of the bed slightly elevated and the wedge cushion under the resident's upper body. All layers were left under the resident.

3. Interview with the wound care nurse on 8/30/23 at 9:23 AM revealed residents should only have a brief, incontinence pad, and sheet under them if they were at risk for skin breakdown and used an air mattress. Further interview revealed, if the resident had a Foley catheter in place, the resident should only have 1 layer between them and the air mattress, especially if the resident was able to call for a bed pan. Further interview revealed resident requests for additional layers should be indicated on the resident's care plan.

4. Telephone interview with the DON on 8/30/23 at 9:49 AM revealed resident repositioning was expected to be performed every 2 to 4 hours depending on the care plan and residents with an air mattress should only have a sheet and pad specific for the air mattress (incontinence pad/barrier pad) under them. The DON confirmed resident requests for additional layers should be on the care plan and revealed if the resident had actual wounds staff should follow the wound care team recommendations.

5. Review of the manufacturer's recommendations titled "PressureGuard Bariatric APM [Alternating Pressure Mattress]" provided by the facility on 8/30/23 showed "...Bed Linens: Seven-inch deep fitted sheets are recommended. Multiple layers of linens or underpads beneath the patient should be avoided for the prevention and treatment of pressure injuries."

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F 686	Continued From page 18 6. Review of the policy titled "Pressure Injury Prevention guidelines" dated 6/26/23 showed "...5. Prevention devices will be utilized in accordance with manufacturer's recommendations (e.g., heel flotation devices, cushions, mattresses)..."	F 686		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the 2022 U.S. Public Health Service Food Code, the facility failed to ensure proper hand hygiene during 1 of 1 food preparation observations. The census was 42. The findings were: 1. Observation on 8/29/23 at 11:45 AM showed	F 812	1. The facility will ensure proper hand hygiene during food preparation observations. 2. All food employees will be educated that they may not contact exposed, ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatula, tongs, single-use gloves, or	10/16/23

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F 812	Continued From page 19 cook #1 and dietary aide #1 were preparing to serve the noon meal. Dietary aide #1 was wearing gloves and performing various tasks throughout the kitchen. At 11:56 AM dietary aide #1 was observed placing his gloved hand into a pitcher of ice, transferred the ice to a beverage cup, added iced tea to the container, and placed the cup on a tray to be delivered to a resident. At 12:22 PM the dietary aide (wearing the same gloves) again placed his gloved hand into the pitcher of ice, transferred the ice to a beverage cup, added liquid to the cup, and then gave the cup to a CNA to deliver to a resident. 2. Interview with the certified dietary manager on 8/29/23 at 2:36 PM revealed it was her expectation staff members use a scoop when handling ice. 3. Review of the 2022 U.S. Public Health Service Food Code showed "...3-301.11 Preventing Contamination from Hands (B) Except when washing fruits and vegetables as specified under §3-302.15 or as specified in ¶¶ (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT."	F 812	dispensing equipment. 3. Dietary Manager or designee will audit three various timed meals a month to ensure that proper hand hygiene during food preparation is being done. 4. The audits will be brought to QAPI for 90 days or until resolved.	
F 880 SS=D	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	F 880		10/16/23

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diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions 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

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F 880	Continued From page 21 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention and control practices were implemented for 1 of 3 residents (#37) reviewed for wound care. The findings were: 1. Review of the 8/11/23 quarterly MDS assessment for resident #37 showed the resident had a BIMS score of 11 out of 15, which indicated the resident had moderately impaired cognition, and diagnoses which included a wound infection, methicillin resistant Staphylococcus aureus infection (MRSA), and a cutaneous abscess. Further review showed the resident had a surgical wound with an application of a nonsurgical dressing and received an antibiotic 7 days out of the 7-day look-back period. The	F 880	1. The facility will ensure infection prevention and control practices are implemented for all residents at all times. 2. Resident #37 will have wound care done by his/her staff practice hand hygiene; ensuring infection prevention and control are practiced. 3. All residents who receive wound care done by his/her staff, staff will practice hand hygiene ensuring infection prevention and control. 4. All staff including therapy staff will be educated on DCC's infection prevention and control practices. 5. IC nurse or designee will do audits of wound care with therapies will be audited to ensure that DCC's infection prevention and control practices are being done per	

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F 880	Continued From page 22 following concerns were identified: a. Observation on 8/28/23 at 1:50 PM showed the wound care nurse and PTA #1 entered the resident's room wearing gowns, gloves, and masks. During wound care PTA #1 used his gloved hand to remove an old and rolled up dressing from the left side of the resident's back. PTA #1 cleaned the resident's wound, and without performing hand hygiene and changing gloves inserted a cotton-tipped applicator to measure the depth of the wound, and used sterile swabs to obtain a sample for culture. Blood was noted on the end of the swabs, and leaking from the open wound. PTA #1, still wearing the same gloves, packed the wound with wound packing using a sterile cotton-tipped applicator, and the wound care nurse applied a clean dressing. No hand hygiene or glove change was performed throughout the wound care procedure. Interview with PTA #1 and the wound care nurse, at that time, confirmed PTA #1 did not perform hand hygiene after cleansing the wound and before applying dressing. 2. Interview with the infection preventionist on 8/30/23 at 12:15 PM revealed she expected hand hygiene to be performed after contact with a contaminated body area or before starting an aseptic procedure such as applying a new dressing. 3. Review of the facility policy titled "Clean Dressing Change", dated 6/26/23, showed: "...7. Wash hands and put on clean gloves...9...remove the existing dressing. 10. Remove gloves, pulling inside out over the dressing. Discard into the appropriate receptacle. 11. Wash hands and put on clean gloves. Cleanse the wound as ordered, taking care not to contaminate other skin	F 880	policy audits will be done monthly. 6. The results of the audit will be brought to QAPI for 90 days or until resolved.	

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F 880	Continued From page 23 surfaces...13. Measure wound using disposable measuring guide...14. Wash hands and put on clean gloves. 15...dress the wound as ordered...17. Discard disposable items and gloves...and wash hands."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		10/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 883	Continued From page 24 (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 (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 offered and/or administered to 1 of 5 sample residents (#37) reviewed for immunizations. The findings were: 1. Review of the annual MDS assessment dated 7/21/23 showed resident #37 admitted to the facility on 7/11/22 and the resident did not receive the influenza or pneumococcal vaccines. Further review showed the resident was offered the vaccinations and declined administration. However, review of the medical record showed no evidence the influenza or pneumococcal vaccinations were offered, accepted/declined, or	F 883	1. The facility will ensure vaccinations are offered and/or administered. 2. Resident #37 will be offered the influenza and pneumococcal vaccines, and his/her medical record will reflect that. 3. All residents will be offered the influenza and pneumococcal vaccines, and his/her medical record will reflect that. 4. Administrative nurses will be educated that all residents need to be offered the influenza and pneumococcal vaccines, and his/her medical record will reflect that. 5. An audit of all current residents will be done to ensure that they have been	

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F 883	Continued From page 25 administered in the facility or community. 2. Interview with the infection preventionist on 8/30/23 at 8:45 AM confirmed there was no evidence the influenza or pneumococcal vaccinations were offered, accepted/declined, or administered in the facility or community. 3. Review of the policy titled "Infection Prevention and Control Program" dated 5/22/23 showed "...7. Influenza and Pneumococcal Immunization: Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received vaccines elsewhere...e. Documentation will reflect the education provided and details regarding whether or not the resident received immunizations..."	F 883	offered the influenza and pneumococcal vaccines and his/her medical record reflect that. 6. An audit of all new admission from October 1-March 31 will be done to ensure that they have been offered the influenza and pneumococcal vaccines and his/her medical chart reflect that. 7. The results of the audit will be brought to QAPI until April 2024 QAPI to ensure all residents have been offered the influenza and pneumococcal vaccine and his/her medical chart reflect that.	