STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/25/23 to 9/28/23. Also reviewed in the course of the survey was complaint intake WY00003653. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set RAI: Resident Assessment Instrument Less commonly used abbreviations will be annotated in each deficiency.	F 000	Type text here	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, MDS 3.0 RAI manual review, and policy and procedure review, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 2 of 18 sample residents (#19, #25). The findings were: 1. Review of the quarterly MDS assessment dated 7/29/23 showed resident #25 was coded as having a stage 3 pressure ulcer. Review of the comprehensive MDS assessment dated 5/6/23 showed the resident was coded as having a stage 3 pressure ulcer. The following concerns were identified:	F 641		

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

Administrator 10/26/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 a. Review of the medical record showed no evidence the resident had a pressure ulcer since 2021. b. Interview with DON on 9/27/23 at 9:54 AM confirmed the resident did not have an actual wound since 2021 and the MDS assessments were not accurate. c. According to the MDS RAI Manual version 1.71.1 page 440 showed "...Coding Instructions for M0300C M0300C1 Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3. Enter 0 if no Stage 3 pressure ulcers are present and skip to M0300D, Stage 4..." 2. Review of the annual MDS assessment dated 5/13/23 showed resident #19 was coded as having one fall with no injury. Review of the quarterly MDS assessment dated 8/5/23 showed the resident did not receive any scheduled or PRN (as needed) pain medication, and had no falls since admission/entry, reentry, or prior assessment. The following concerns were identified: a. Review of the risk management report for the resident showed the resident had falls on 12/4/22, 2/13/23, 4/12/23 and 6/15/23, for a total of 4 falls. b. Review of the medication administration record for July 2023 and August 2023 showed the resident received scheduled pain medication for 7 out of 7 days during the MDS look-back period. c. Interview with the DON on 9/27/23 at 2:50 PM confirmed the MDS assessments were not accurate. d. According to the MDS RAI Manual version 1.71.1 page 362, "Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen Code 0, no: if the medical record does not contain	F 641	F641- Accuracy of Assessments. 1.) Quarterly and Annual MDS assessments (11/26/22, 5/6/23, 7/29/23) for resident #25 were corrected on 9/27/23 to appropriately show the stage 3 wound as a scar over bony prominences/healed. 2.) Resident #19 MDS assessments inaccurately reflected the number of falls. The Quarterly and Annual MDS assessments (5/13/23, 8/5/23) were corrected on 9/27/23. 3) Newly hired MDS Coordinator advised of possibility of erroneous prior assessments and Ftag from this survey. WRC recognizes that inaccurate assessments could affect all residents. DON or designee to audit assessments for accuracy 25% of weekly MDS submissions to be audited for accurate completion of skin conditions and falls. Audits to be completed weekly for the next 3 months. Results of audit to be reported to QAPI committee at monthly meeting.QAPI committee will review and make recommendations until substantial compliance is reached	This will be completed by ~~12/15/2024~~ 12/15/23

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F 641	Continued From page 2 documentation that a scheduled pain medication was received. Code 1, yes: if the medical record contains documentation that a scheduled pain medication was received. Coding Instructions for J0100B, Received PRN Pain Medication Code 0, no: if the medical record does not contain documentation that a PRN medication was received or offered. o Code 1, yes: if the medical record contains documentation that a PRN medication was either received OR was offered but declined..." e. According to the MDS RAI Manual version 1.71.1 page 391, "...J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100) if the assessment being completed is an OBRA assessment. If the assessment being completed is a Scheduled PPS assessment, skip to Prior Surgery item (J2000). Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent..."	F 641		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692	Type text here	

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F 692	Continued From page 3 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. 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 an adequate assessment was performed and appropriate interventions were implemented for 1 of 4 sample residents (#25) reviewed for nutrition. The findings were: 1. Review of the quarterly MDS assessment dated 7/29/23 showed resident #25 had diagnoses which included renal insufficiency, renal failure, or end-stage renal disease, Parkinson's disease, other specified nutrition deficiencies, and gastro-esophageal reflux disease. Further review showed the resident required extensive physical assistance of 1 person for eating and no weight loss was indicated. The following concerns were identified: a. Review of the resident's weight history showed the resident weighed 167.3 pounds on 7/30/23 and 151 pounds on 8/7/23 which was a 16.3 pound or 9.74% loss, in 8 days. The resident weighed 129.8 pounds on 8/30/23 which was a 37.5 pound or 22.41% loss, in 31 days. The resident's weight continued to decrease to 127.4 on 9/17/23 and 126.8 on 9/24/23. Further review	F 692	Type text here	

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F 692	Continued From page 4 showed there was no evidence a re-weight was obtained for the 8/7/23 or 8/30/23 weights. b. Review of the meal intake record from 7/31/23 to 8/7/23 showed out of 27 meals, the resident consumed 0 percent to 25 percent of meals 5 times, 26 percent to 50 percent 9 times, 51 percent to 75 percent 5 times, 76 percent to 100 percent 6 times, and refused meals 2 times. Review of the meal intake record from 8/8/23 to 8/30/23 showed out of 69 meals, the resident consumed 0 percent to 25 percent 9 times, 26 percent to 50 percent 5 times, 51 percent to 75 percent 17 times, 76 percent to 100 percent 35 times, refused meals 1 time, and was documented not applicable 2 times. c. Review of the nutritional supplement intake record for 7/31/23 through 8/7/23 showed the resident consumed a daily average of 215 milliliters (ml) in the morning, 180 ml at lunch time, and 150 ml in the evening, of his/her nutritional supplements. Review of the nutritional supplement intake record for 8/8/23 through 8/30/23 showed the resident consumed a daily average of 172 ml in the morning, 196 ml at lunch time, and 105 ml in the evening, of his/her nutritional supplements d. Review of the medical record showed the last nutrition note was 7/31/23, prior to the weight loss. There was no evidence the weight loss had been identified and evaluated, nor had interventions been implemented as a result of the weight loss. 2. Interview with the dietary manager on 9/27/23 at 9:22 AM revealed the resident received ensure, mighty shakes 3 times per day, and boosted pudding; however, she confirmed the supplements were all ordered prior to the weight loss and there were no interventions implemented	F 692	F692- Nutrition/Hydration Status Maintenance. 1. Resident #25 has been placed on weekly weight monitoring. Meal intake documentation has been updated to specifically address meal, fluid,and supplement intake for all residents. The dietitian has charted on the significant weight loss for the resident and an additional supplement has been added. 2) For all residents, the Dietary manager will audit weights monthly to ensure significant weight changes are identified. When significant changes are identified, the resident will be placed on weekly monitoring and the dietitian will be notified through weight meetings or direct communication. Monitoring will continue until weight stabilization is achieved. In addition the dietician will initiate review of all resident weights monthly to identify any significant weight changes that may have been missed. A record of these reviews will be kept and shared to ensure these residents are reviewed by the IDT. 3) WRC recognizes the potential for all residents to have significant weight change. DON or disignee to conduct audit weekly to ensure residents are weighed according to WRC policy for 1 month then monthly for atleast 3 months or until substantial compliance is met. Audit will be reported for review and recommendation to QAPI committee during monthly meeting until substantial compliance met.	to be completed by 12/15/23

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F 692	Continued From page 5 subsequent to the weight loss. Further interview revealed the dietary manager felt the weight loss was due to the resident's disease progression and the facility's practice was for the dietitian to be notified of any identified weight loss. 3. Interview with the dietitian on 9/27/23 at 9:28 AM revealed she was unsure why the resident had such a large weight loss and confirmed she was not aware the weight loss had occurred. She revealed the resident was listed on the schedule for discussion at the weight meeting scheduled for that day and the facility IDT (interdisciplinary team) discussed all weight loss in the weight meeting. She revealed when weight loss was identified, the facility monitored weights twice per month as an IDT in the weight meeting and attempt to identify reasons the weight loss occurred to develop appropriate interventions. Further interview revealed she was unsure what additional interventions could be implemented for the resident and stated the resident was at a healthy body mass index. 4. Review of the policy titled "Weight Assessment and Intervention" last revised March 2022 showed "...3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. 4. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time...5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight-actual weight)/(usual weight) x 100]: a. 1 month-5% weight loss is significant; greater than 5% is severe. b. 3 months-7.5% weight loss is significant; greater than 7.5% is severe. c. 6	F 692	F692- Nutrition/Hydration Status Maintenance. 1. Resident #25 has been placed on weekly weight monitoring. Meal intake documentation has been updated to specifically address meal, fluid,and supplement intake for all residents. The dietitian has charted on the significant weight loss for the resident and an additional supplement has been added. 2) For all residents, the Dietary manager will audit weights monthly to ensure significant weight changes are identified. When significant changes are identified, the resident will be placed on weekly monitoring and the dietitian will be notified through weight meetings or direct communication. Monitoring will continue until weight stabilization is achieved. In addition the dietician will initiate review of all resident weights monthly to identify any significant weight changes that may have been missed. A record of these reviews will be kept and shared to ensure these residents are reviewed by the IDT. 3) WRC recognizes the potential for all residents to have significant weight change. DON or disignee to conduct audit weekly to ensure residents are weighed according to WRC policy for 1 month then monthly for atleast 3 months or until substantial compliance is met. Audit will be reported for review and recommendation to QAPI committee during monthly meeting until substantial compliance met.	

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F 692	Continued From page 6 months-10% weight loss is significant; greater than 10% is severe...Evaluation...1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. The evaluation includes: a. the resident's target weight range (including rationale if different from ideal body weight); b. the resident's calorie, protein, and other nutrient needs compared with the resident's current intake; c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. whether and to what extent weight stabilization or improvement can be anticipated..."	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		

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F 758	Continued From page 7 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §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, staff interview and facility policy review, the facility failed to ensure a gradual dose reduction or risk versus benefit was performed for 1 of 5 sample residents (#39) reviewed for unnecessary medications. In addition, the facility failed to ensure as needed psychotropic medications were not ordered for greater than 14 days without physician rationale for 1 of 5 sample residents (#4) unnecessary medications. The findings were: 1. Review of the 9/16/23 quarterly MDS	F 758	F758 Free from Unnecessary Psychotropic meds/PRN Use 1. Resident #4 and #39 were identified to have moderate cognitive impairment according to their BIMS scores. Pharmacy recommendation was not followed for GDR for either resident. Physician did not provide risk versus benefit recommendations for either patient. Education will be provided to primary care providers including the regulation and pathway for FTag758. WRC recognizes the potential for all residents to receive pharmacy recommendations. DON or designee will audit pharmacy consultation reports after physician has reviewed them to ensure each recommendation is addressed and risk vs. management statements written for all GDR recommendations. Audit to continue monthly for 3 months then quarterly for 3 quarters or until substantial compliance has been met. Results of audits to be presented at monthly QAPI meetings for review and recommendation until substantial compliance is met Resident #4 PRN order for lorazepam has been discontinued	This will be completed by 12/15/2023 completed 10/26/23

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F 758	Continued From page 8 assessment for resident #4 showed the resident had a brief interview for mental status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment, and diagnoses which included anxiety and depression. Review of the physician's orders for September 2023 showed the resident received lorazepam 0.5 mg1 tablet by mouth every 12 hours as needed (PRN) for lifetime of patient, related to anxiety disorder ordered on 2/23/22. Review of the resident's care plan last revised on 6/27/23 showed to consult with the pharmacy and the physician to consider dosage reduction when clinically appropriate at least quarterly. The following concerns were identified: a. Review of a pharmacy "consultation report" dated 5/15/23 showed the resident was on lorazepam twice a day and a gradual dose reduction was recommended; however, there was no recommendation for the as needed lorazepam. Further review showed there was no evidence the physician provided a risk versus benefit or rationale for continued use of the as needed lorazepam. b. Interview with the DON on 9/28/23 at 10:15 AM revealed the order was not an error and the resident had been on the as needed lorazepam for several years. Further interview revealed the resident went through cycles of taking the as needed lorazepam and had a "for lifetime of patient" duration per the doctor; however, the resident had not received the as needed lorazepam from 7/1/23 through 9/28/23. 2. Review of the quarterly MDS assessment dated 8/19/23 showed resident #39 had a BIMS score of 9 out 15, which indicated moderate cognitive impairment, and had diagnoses which included non-Alzheimer's dementia, anxiety	F 758		

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F 758	Continued From page 9	F 758		

disorder, depression, psychotic disorder other than schizophrenia, and post-traumatic stress disorder. Further review showed the resident received antipsychotic medication, antianxiety medication, and antidepressant medication on 7 out 7 days during the look-back period. Review of the September 2023 physician orders showed the resident received escitalopram (antidepressant) 20 milligrams (mg) by mouth every night shift for major depressive disorder, single episode, severe with psychotic features, lorazepam (antianxiety) 1 mg by mouth twice per day for generalized anxiety and panic disorder, and risperidone (antipsychotic) 0.5 mg every morning and at bedtime for delusional disorders. The following concerns were identified:

a. Review of a pharmacy "consultation report" dated 4/7/22 showed escitalopram 10 mg every HS (hours of sleep) was ordered on 10/20/21 and was increased to 20 mg on 12/18/21 and lorazepam 1 mg as needed was ordered on 10/20/21 and changed from as needed to twice per day on 12/13/21. Recommendations included "Please review both medications and consider a gradual dose reduction to lorazepam 0.5 mg BID, while concurrently monitoring for reemergence of target and/or withdrawal symptoms. If a reduction is escitalopram [sic] would be more appropriate at this time, consider 10 mg QHS [every hours of sleep]. Recommend only making changes to one medication at a time..." Further review showed no evidence of a physician response to the recommendation and a note which indicated "psych will eval [evaluate] tx [treatment]."

b. Review of the medical record showed no evidence a gradual dose reduction or risk versus benefit statement and physician rationale for the lorazepam or escitalopram since they were ordered. In addition, the facility was unable to

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F 758	Continued From page 10 provide evidence a gradual dose reduction or risk versus benefit was performed. 3. Interview with the administrator on 9/28/23 at 10:49 AM revealed she expected the gradual dose reduction to be completed at least annually for psychotropic medications. 4. Interview with the DON on 9/28/23 at 11:08 AM revealed gradual dose reductions and risk versus benefit were to be completed twice per year. 5. Review of a policy titled "Gradual Dose Reduction" provided by the facility on 9/28/23 showed "...1. The WRC Multidisciplinary Care Planning Team and/or Pharmacist will review each resident's drug regimen, identify psychotropic medications, and determine if initiation of a "Request for Gradual Dose Reduction" is indicated per required Federal Regulation timetable for such medication(s)...3. After review of the resident's medication regimen and clinical record, the attending physician will determine if a dosage reduction is appropriate, and will write and order to reflect this determination. Justification of why a particular drug/dosage is in the best interest of the resident may include, but are not limited to: A. A physician's note indicating that the use of the drug, or continued use of the drug is clinically appropriate and the reasons why this use is clinically appropriate. This note must demonstrate that the physician has carefully considered the risk/benefit to the resident in using drugs outside the guidelines..."	F 758		