STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE COUNTY HEALTH	**333 N BRIDGER AVE PINEDALE, WY 82941**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/20/24 to 2/23/24. Also reviewed in the course of the survey was complaint intake WY000003662. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 656 SS=E	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).	F 656		4/4/24

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

Electronically Signed | 03/14/2024

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F 656	Continued From page 1 (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. (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 medical record review and resident and staff interview, the facility failed to develop a comprehensive care plan for 4 of 15 sample residents (#4, #9, #12, #20). The findings were: 1. Review of the 12/15/23 admission MDS assessment showed resident #4 received opioid medication and had indicators of pain on 3-4 days during the look-back period. Further review of the assessment showed pain triggered and review of the care area assessment (CAA) for pain showed the resident had a recent fracture, a weekly Butrans patch, oxycodone, and Tylenol was used	F 656	F656: Comprehensive Care Plans: The facility failed to develop a comprehensive care plan for 4 of 15 sample residents noted as follows: a. Resident #4 was noted to have a PRN pain medication and trigger for pain on the MDS care area assessment, however, resident #4 did not have a care plan addressing pain. To correct this deficiency, the MDS coordinator input a care plan addressing	

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F 656	Continued From page 2 to control pain. Review of current orders and the February 2024 MAR showed the resident was ordered the following medications for pain: acetaminophen 325 mg, 2 tablets, every 6 hours PRN; Butrans patch weekly, 7.5 mcg/hour, on Friday; morphine concentrate 100 mg/5ml, 0.4 mL (8 mg), four times a day; and morphine concentrate 100 mg/5 mL, 0.4 ml (8 mg) every 8 hours PRN. The following concerns were identified: a. Review of the care plan provided by the facility on 2/22/24 at 4:53 PM showed pain was not addressed. b. During an interview on 2/23/24 at 9:15 AM the DON confirmed the care plan did not address pain. She stated care plans were developed for triggered items on the MDS and she was not sure why the care plan didn't address pain. 2. Review of the 11/13/23 admission MDS assessment showed resident #20 had a diagnosis of hip fracture, received opioid medication, and had pain frequently at a "7" on a scale of 0 to 10. Further review of the assessment showed pain triggered and review of the CAA for pain showed the resident had a recent hip surgery and reported his/her worst pain was a 7 out of 10. Review of physician orders and the February 2024 MAR showed the resident was ordered the following medications for pain: acetaminophen 325 mg, 2 tabs, every 6 hours PRN; Fentanyl patch 72 hour, 25 mcg/hr, every 72 hours; and hydrocodone-acetaminophen 5-325 mg, 1 tab, every 4 hours PRN. The following concerns were identified: a. Review of the care plan provided by the facility on 2/22/24 at 4:40 PM showed pain was not addressed. b. During an interview on 2/23/24 at 9:15 AM	F 656	pain. To ensure appropriate care planning for all residents, the MDS coordinator performed an audit of all residents receiving pain medications to ensure each had a care plan addressing pain. Further missing care plans were created at that time. To prevent future deficiencies, each resident's individual, written care plan will be brought to each care conference for review and audit by the inter-disciplinary team to provide an extra layer of auditing that ensures care plans are accurate. All staff were provided education regarding the deficiency. The MDS coordinator will report on accuracy of care plans at quarterly QAPI meeting. b. Resident #20 was noted to have a diagnosis of hip fracture, received opioid medication and had pain frequently at a 7 on a scale of 0-10. However, resident #20 did not have a care plan addressing pain. To correct this deficiency, the MDS coordinator input a care plan addressing pain. To ensure appropriate care planning for all residents, the MDS coordinator performed an audit of all residents receiving pain medications to ensure each had a care plan addressing pain. Further missing care plans were created at that time. To prevent future deficiencies, each resident's individual, written care plan will be brought to each care conference for review and audit by the inter-disciplinary team to provide an extra layer of auditing that ensures care plans are accurate. All staff were provided education regarding the deficiency. The MDS coordinator will	

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F 656	Continued From page 3	F 656		

the DON confirmed the care plan did not address pain. She stated care plans were developed for triggered items on the MDS and she was not sure why the care plan didn't address pain.

3. Review of the 7/5/24 annual MDS assessment showed resident #12 had diagnoses which included arthritis, non-Alzheimer's dementia, dementia in other diseases classified elsewhere, severe, with psychotic disturbance, polyarthritis, pain, edema, repeated falls, and urinary tract infection. The resident was at risk for pressure ulcers and had 1 unstageable pressure ulcer. The facility's treatment for the pressure ulcers included a pressure reducing surface for the chair and bed, nutrition, and ointments. Review of the 12/18/23 quarterly MDS assessment showed the resident had a stage 2 pressure ulcer. The following concerns were identified:

a. Review of the 7/5/23 annual MDS care area assessment showed pressure ulcers were triggered and care planned.

b. Review of the care plan showed "Risk for impaired skin integrity [related to] R/T urinary incontinence requiring extensive assistance with toileting with the goal target date of 1/1/24." The care plan did not address the actual stage 2 pressure ulcer.

c. During an interview on 2/23/24 at 9:15 AM the DON confirmed the care plan did not address pressure ulcers. She stated care plans were developed for triggered items on the MDS and she was not sure why the care plan didn't address the pressure ulcer.

4. Review of the 1/8/24 annual MDS assessment showed resident #9 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The resident had behaviors of rejection of

report on accuracy of care plans at quarterly QAPI meeting.

c. Resident #12 had an assessment which noted risk for pressure ulcer and had 1 unstageable pressure ulcer. Further, resident had a previous stage 2 pressure ulcer. Interventions, including pressure relieving devices, nutrition and ointment were identified. Despite risk and implementations, resident #12 had a care plan for "risk of impaired skin integrity" and did not address the actual pressure ulcer.

To correct this deficiency, the MDS coordinator adjusted the "risk for impaired skin integrity" to reflect actual skin integrity impairment and current interventions for resident #12. To ensure appropriate care planning for all residents, the MDS coordinator performed an audit of all residents noted to have skin issues or receiving skin integrity interventions. No further issues were noted. To prevent future deficiencies, each resident's individual, written care plan will be brought to each care conference for review and audit by the inter-disciplinary team to provide an extra layer of auditing that ensures care plans are accurate. All staff were provided education regarding the deficiency. The MDS coordinator will report on accuracy of care plans at quarterly QAPI meeting.

d. Resident #9 was interviewed and advised that the facility took electric wheelchair away without adequate

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F 656	Continued From page 4 care. The mobility device used in the last 7 days was a wheelchair. The resident had diagnoses which included medically complex conditions, non-Alzheimer's dementia, anxiety, depression, bipolar, chronic obstructive pulmonary disease, Respiratory failure, Encephalopathy, Morbid (severe) obesity due to excess calories, Unspecified dementia, unspecified severity, with anxiety, and anoxic brain damage. The following concerns were identified: a. Interview with the resident on 2/21/24 at 2 PM revealed "I had to work to lose 30 pounds to get an electric wheel-chair. We got a new doctor and new DON and they took it from me. It limits me from where I can go, and when I can go. They did not have a reason why." Interview with the resident on 2/23/24 at 8:57 AM revealed the facility never went over alternatives for his/her wants to go to town. b. Review of the care plan last revised on 1/9/24 showed there were no interventions related to access to the community following the removal of the electric wheelchair. c. Interview with the DON on 2/22/24 at 4:08 PM revealed the resident would need to use transportation services to access the community and the service would cost money. Further interview revealed the resident did not have money for the transportation service.	F 656	rationale. Further interview with resident advised that facility never went over alternatives for his desire to travel to town. Review of the care plan showed no interventions related to community access. To correct the deficiency, MDS coordinator input a community access care plan that includes community transportation support. To identify further issues, the MDS coordinator reviewed care plans for all residents identified as having a desire to travel into community independently and ensured they each had an appropriate care plan. To encourage future compliance, social services will identify all residents desiring to travel into community independently have access to community contacts for transportation, are aware that facility provides transportation to medical appointments and to most community events, and identifies barriers to independence within the community. Both MDS and Social Services will report as a function of regularly scheduled QAPI meetings. Resident #9 was also provided rational, in writing, for the safety reasons the electric wheelchair was changed back to a manual wheelchair. Facility will follow up to ensure retention of that education and request physician provide medical rationale at his next, scheduled visit 04/04/2024. The facility created a form for resident signature that may be used whenever significant care plan changes occur, to ensure adequate education for all residents.	

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility protocol, the facility failed to implement interventions to treat constipation for 3 of 3 sample residents (#4, #10, #20) reviewed for bowel management due to opioid medication use. The findings were: 1. Review of the 12/15/23 admission MDS assessment showed resident #4 had a femur fracture and received opioid medication. Review of current orders and the February 2024 MAR showed the resident was ordered the following opioid medications: Butrans patch weekly, 7.5 mcg/hour, on Friday; morphine concentrate 100 mg/5ml, 0.4 mL (8 mg), four times a day; and morphine concentrate 100 mg/5 mL, 0.4 ml (8 mg) every 8 hours PRN. The following concerns were identified: a. Review of the bowel movement (BM) record for the past 28 days showed the resident had no BM for 4 days on two occasions (2/9/24-2/12/24 and 2/17/24-2/20/24). b. Review of the February 2024 MAR and progress notes showed no evidence the resident received any interventions for constipation during those timeframes.	F 684	F684: Quality of Care: The facility failed to implement interventions to treat constipation as follows: a. Resident #4 had a femur fracture and received opioid medication. Review of the BM record for 28 days revealed no BM x 4 days on two separate occasions with no evidence the resident received any interventions for constipation during those time frames. To correct the current deficiency, the resident's medical record was reviewed to ensure bowel movements have occurred. To ensure quality of care for all other residents, medical record audit was completed to ensure no other residents had gone multiple days without BM & without intervention. Identified issues were corrected on date of audit. To ensure future continued compliance, standing orders were entered into Matrix to ensure accountability and documentation. Education will be provided to all nursing staff regarding new process and	3/20/24

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F 684	Continued From page 6 2. Review of the 1/31/24 admission MDS assessment showed resident #10 had almost constant pain. Review of physician orders showed the resident was ordered the following opioid medications: morphine 15 mg twice per day and oxycodone 5 mg every 6 hours PRN. In addition, the resident was ordered polyethylene glycol 3350 powder (used to treat constipation), 17 gram/dose, every 24 hours PRN. The following concerns were identified: a. Review of the BM record for the last 28 days showed the resident had no BM for 4 days on two occasions (2/3/24-2/6/24 and 2/17/24-2/20/24). b. Review of the February 2024 MAR and progress notes showed no evidence the resident received any interventions for constipation during those timeframes. 3. Review of the 11/13/23 admission MDS assessment showed resident #20 had a diagnosis of hip fracture, had frequent pain, and received opioid medication. Review of physician orders and the February 2024 MAR showed the resident was ordered the following opioid medications: Fentanyl patch 25 mcg every 72 hours and hydrocodone-acetaminophen 5-325 mg every 4 hours PRN. In addition, the resident was ordered Miralax powder, 17 gram/dose, every 48 hours for constipation. Review of a physician's note dated 1/4/24 showed the resident had "drug induced constipation." The following concerns were identified: a. Review of the BM record for the last 28 days showed the resident did not have a BM from 1/29/24-2/2/24 (5 days), 2/4/24-2/8/24 (5 days), and 2/10/24-2/12/24 (3 days). b. Review of the February 2024 and progress	F 684	importance of documentation at clinical staff meeting on March 20, 2024. The Director of Nurses will report on bowel protocol and compliance at the regularly scheduled, QAPI meetings. b. Review of physician orders showed resident #10 was ordered opioid medications. Review of the BM record for the last 28 days showed no BM and no interventions for a period of four days on two occasions. To correct the current deficiency, the resident's medical record was reviewed to ensure bowel movements have occurred. To ensure quality of care for all other residents, medical record audit was completed to ensure no other residents had gone multiple days without BM & without intervention. Identified issues were corrected on date of audit. To ensure future continued compliance, standing orders were entered into Matrix to ensure accountability and documentation. Education will be provided to all nursing staff regarding new process and importance of documentation at clinical staff meeting on March 20, 2024. The Director of Nurses will report on bowel protocol and compliance at the regularly scheduled, QAPI meetings. c. Resident #20 had a diagnosis of hip fracture with ordered opioid medication protocol. Review of the BM record revealed the resident did not have a BM nor receive intervention for a period of five days on two occasions and a period of	

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F 684	Continued From page 7 notes showed no evidence the bowel protocol was followed during those timeframes. 4. During an interview on 2/23/24 at 9:15 AM the DON stated the facility bowel protocol would apply to residents #4, #10, and #20. She stated staff should follow the protocol or contact the provider. She confirmed there was no evidence to show the protocol was followed for residents #4, #10, and #20. 5. Review of the facility's bowel protocol "Constipation Treatment," undated, showed "...Day 1: Drink at least 2 liters of water/fluids daily if not contraindicated. Day 2: Psyllium husks 1 tbsp (3.5 g) three times daily, or 6 prunes twice daily. Day 3: Senna 17-25.6 mg daily or Bisacodyl 10-30 mg daily. Day 4: Polyethylene glycol 17-34 g daily. Day 5: Bisacodyl 10 mg suppository daily. Document bowel sounds. Day 6: Warm water enema daily. Document bowel sounds, notify PCP if no BM."	F 684	three days on one occasion. To correct the current deficiency, the resident's medical record was reviewed to ensure bowel movements have occurred. To ensure quality of care for all other residents, medical record audit was completed to ensure no other residents had gone multiple days without BM & without intervention. Identified issues were corrected on date of audit. To ensure future continued compliance, standing orders were entered into Matrix to ensure accountability and documentation. Education will be provided to all nursing staff regarding new process and importance of documentation at clinical staff meeting on March 20, 2024. The Director of Nurses will report on bowel protocol and compliance at the regularly scheduled, QAPI meetings.	
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---	F 758		3/20/24

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F 758	Continued From page 8 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §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 orders for psychotropic medications were limited to 14 days or the physician documented rationale for an	F 758	F758: Free from Unnecessary Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) The facility failed to ensure orders for	

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F 758	Continued From page 9 extended order, for 1 of 5 sample residents (#34) reviewed for unnecessary medications. The findings were: 1. Review of the 11/22/23 admission MDS assessment showed resident #34 received antianxiety medication and had diagnoses which included dementia and anxiety disorder. The following concerns were identified: a. Review of the current physician orders showed a PRN order for alprazolam (antianxiety) 0.25 mg three times daily which started on 11/20/23 and did not have a stop date. b. On 11/29/23 the pharmacist sent a consultation report to the physician regarding the PRN Alprazolam that did not have a stop date. The pharmacist noted that PRN orders for non-antipsychotic psychotropics were limited to 14 days unless the prescriber documented the rationale for an extended time period. The physician responded on 1/4/24 "I will schedule Rx [prescription]..." c. Review of the physician orders showed an order dated 1/10/24 for alprazolam 0.25 mg every morning; however, the PRN order remained an active order. Review of the February 2024 MAR showed the PRN order remained active, and the resident received a dose on 2/4/24. d. Interview with the DON on 2/23/24 at 9:15 AM confirmed there was no rationale for the PRN medication being longer than 14 days. She stated she sent a message to the physician the day before regarding the PRN order.	F 758	psychotropic medications were limited to 14 days or the physician documented rationale for 1 of 5 sample residents. a. Review of medical for resident #34 revealed that the resident had received anti-anxiety medication and had diagnosis which included dementia and anxiety disorder. However, medication did not have a stop date. Further, consultant pharmacist sent a consultation report to eh physician regarding PRN with no stop date, and the physician responded, "I will schedule Rx (prescription)…". To correct this deficiency, order for resident #34 was clarified to include scheduled anti-anxiety medication along with PRN anti-anxiety medication to be used indefinitely with physician rationale. To ensure that no other residents had orders for PRN psychotropic medication without a stop date, a medical records audit was performed for all residents, and non-compliance was corrected at that time. To promote continued compliance, standing ordered were updated to authorize nursing staff to add 14 day stop date if not specified by prescribing provider. Staff will be educated on the deficiency and process change at 03/20/2024 staff meeting. DON will report on compliance at regularly scheduled, QAPI meetings.	