STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535027	A. BUILDING _____ B. WING _____	C 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CODY REGIONAL HEALTH LONG TERM CARE CENTER	707 SHERIDAN AVENUE CODY, WY 82414

(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 complaint survey was conducted by Healthcare Licensing and Surveys from 2/5/24 to 2/6/24. The survey was prompted by complaint intake(s) WY000003779.	F 000		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, incident log review, and incident investigation review the facility failed to ensure basic life support and advance directives were followed in 1 of 5 sample residents (#1) reviewed for advance directives. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 1/23/24. The findings were: 1. Review the admission minimum data set (MDS) assessment dated 11/7/23 showed resident #1 had a brief interview for mental status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment, and diagnoses which included medically complex conditions, atrial fibrillation or other dysrhythmias, pneumonia, depression, respiratory failure, and anxiety disorder. Review of a provider comprehensive 30 day note dated 1/2/24 and timed 10:52 AM showed "...Code status: Full Code... [S/he] was admitted 10/20/23 - 11/1/23 for	F 678	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 02/21/2024

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 678	Continued From page 1	F 678		

sepsis due to multifocal community-acquired pneumonia (CAP) with acute hypoxic respiratory failure treated with IV antibiotics... Skilled SNF admission for care and physical therapy. Goal is to return to home with assistance from family..." The following concerns were identified:

a. Review of a progress note dated 1/16/24 and timed 9:30 AM showed "...Writer stated that if s/he wished to pursue hospice, communication could be sent to Doctor (Dr.) [name] for orders to be evaluated...[Daughter name] stated that she thinks the [facility name] would better suite [residents' name]. This information an [sic] request was discussed with nursing management to begin the process of getting hospice orders and a referral for services..."

b. Review of a progress noted dated 1/16/24 and timed 10:37 AM showed "... [Daughter name] asked that we review options for hospice and keeping his/her mother/father comfortable. Social worker and writer will review with attending..."

c. Review of a progress note dated 1/16/24 and timed 12:02 PM showed "...Writer communicated with Dr [name] and updated conversation from daughter [name] and social worker. Dr [name] agreed with request for hospice evaluation..."

d. Review of a progress note dated 1/16/24 and timed 9 PM showed "...Resident sleeping respiratory rate - 28..."

e. Review of a progress note dated 1/16/24 and timed 9:33 PM showed "...Resident stopped breathing at 9:15 PM. House supervisor came, pronounced death at 9:20 PM. Called POA at 9:26 PM. Family wants to come in and view resident..."

f. Interview with the LPN #1 on 2/6/24 at 8:25 AM confirmed he was the nurse on shift when resident #1 passed away and revealed he did not

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know or check the resident's code status at the time of passing. The LPN revealed the resident was in a lot of pain and the LPN was trying to get it under control. The LPN revealed he had heard the resident was on hospice when s/he passed away and his/her respirations were 28 when last checked. The LPN revealed he contacted the unit manager and they both thought the resident was DNR because of hospice. The LPN revealed when he identified the resident's code status was full code, he did not feel it would look good to initiate CPR as the family was already at the facility.

2. Review of the policy and procedure titled "Code Blue Procedure" provided by the administrator on 2/5/24 at 4:59 PM showed "...In the event of a cardiac arrest or respiratory arrest, verify Code status in electronic medical record (EMR). Once verified, Basic Life Support (CPR) will be initiated per code orders and continued until the EMS arrives..."

3. Review of the "Advanced Directive Action Plan LTC" dated 1/17/24 showed the following:

a. Review of the "Incident Report - with Follow-up" as of 2/5/24 showed the facility interviewed the LPN and other staff on duty at the time of the incident. The report showed the staff member did not follow policy/process for code status. The staff member was suspended and terminated. All appropriate agencies were contacted.

b. The facility verified all resident code status was correct beginning 1/17/24.

c. The facility performed in-service and 1:1 education beginning on 1/17/24. Staff signatures of attendance were verified during the survey.

d. The facility updated the policy on 1/23/24.

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F 678	Continued From page 3 e. The facility initiated resident code status review at each care conference beginning 1/18/24. 4. Review of the QAPI monthly agenda showed the facility addressed resident code status in January and February meetings. 5. Reviewed the IDT tracking sheets showed the facility team met 3 times a week and under the orders section of their audit triggered any changes or new orders including code status. 6. Review of the staff education "Resident Code Status" dated 1/17/24 showed the facility had educated the staff. Interviews during the survey confirmed staff education was completed.	F 678		