STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	**542 16TH STREET RAWLINS, WY 82301**

(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 4/29/24 through 5/2/24. Also reviewed in the course of the survey were complaint intakes WY00003866 and WY00003876. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide CPR: cardiopulmonary resuscitation LPN: Licensed Practical Nurse MAR: Medication Administration Record mcg: microgram mEq: milliequivalent ml: milliliter RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 678 SS=J	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 and physician interview, and policy review, the facility failed to provide CPR in accordance with a resident's advance directive for 1 of 1 sample resident (#36) who expired. The emergency happened shortly after admission. The facility had	F 678	POC F678 1.) Resident #36 has expired. 2.) Initial audit completed by Social Services Director/Designee for POLST forms for current residents to verify code status and physician signatures. Initial	5/3/24

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

Electronically Signed | 05/24/2024

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F 678	Continued From page 1 not identified the issue, which left all new admits at risk and a determination of immediate jeopardy. The census was 35 and there were two new admits in the last 30 days. The findings were: 1. Medical record review for resident #36 showed an admission and discharge date of 2/13/24. Further review showed the resident signed the admission paperwork, including a POLST [physician orders for life-sustaining treatment] dated 2/13/24 that indicated the resident chose to be a full code. The POLST was signed by the physician on 2/13/24. The nurse admission evaluation was completed by LPN #1 on 2/13/24 at 2:43 PM and the resident was alert and oriented. The following concerns were identified: a. Review of a progress note on 2/13/24 at 6:15 PM showed two RN's (RN #1 and RN #2) were providing care to the resident when s/he "became unresponsive" and lost signs of life. The note did not show that CPR was done on the resident. b. Interview with the administrator (RN #1) on 5/1/24 at 5:03 PM revealed she had heard the resident was a DNR/DNI in the hospital and did not start CPR on the resident. She was unaware that in the event of a cardiopulmonary arrest the resident and physician had signed a POLST that requested CPR. An additional interview on 5/2/24 at 11 AM revealed the resident showed signs of mottling to the extremities just prior to the resident becoming unresponsive and the physician was notified. However, further review of progress notes showed no documentation of mottling or notification of the physician prior to notification of the death. c. Interview with LPN #1 on 5/2/24 at 9:05 AM revealed he admitted the resident and did not	F 678	audit completed by DNS/Designee for licensed nurses CPR certification status. 3.) Education provided to staff by DNS/Designee related to current CPR/Code Blue process, verification of POLST form directives, and initiation of Code Blue. Ongoing weekly, times three months audits completed by DNS/Designee to verify up to date CPR certification for current licensed nurse staff. Twice monthly, times three months audits completed by Social Services Director/Designee for current resident□s POLST forms to ensure code status is identified and physician□s signature is present. Mock Code Blue drill will be completed monthly times three months. 4.) Results of initial and ongoing audits will be reviewed via the QAPI process monthly times three months for further recommendations.	

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F 678	Continued From page 2	F 678		

recall the resident stating a code status.

d. Interview with social worker #1 on 5/2/24 at 9:12 AM revealed when a new resident arrived at the facility, medical records personnel met with the resident to process the admission paperwork, including the POLST.

e. Interview with CNA #1 on 5/2/24 at 9:20 AM verified the residents' POLST and code status documents were kept in the "disaster recovery binder" at the nurses station. A random check of two residents verified the information in the binder was correct and there was a tab with resident #36's name on it but the POLST was no longer in the binder.

f. Interview with the DON (RN #2) on 5/2/24 at 9:30 AM revealed she was providing care to the resident when s/he lost consciousness and did not have a pulse. She had heard that while hospitalized the resident chose a DNR/DNI status and she was not aware the resident had signed a POLST earlier in the day requesting CPR in the event of a cardiopulmonary arrest.

g. Interview with physician #1 on 5/2/24 at 12:50 AM revealed he had signed the resident's POLST and was aware of the resident's pending admission to the facility but had not yet seen the resident. He further revealed he had not been notified of any concerns the facility had regarding the resident until the notification of the resident's death.

2. Review of the personnel files for the DON and the administrator showed both were currently certified in CPR.

3. Review of the admission packet, last revised December 2023, showed "...The center will abide by any instructions provided in your Advance Directive, Living Will, Health Care Power of

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F 678	Continued From page 3	F 678		

Attorney, other Directive, or any POLST/POST issued by your physician. If you have not provided an Advance Directive or if a POLST/POST has not been issued, the Center will take all appropriate actions during an emergency, including administering CPR, calling 911 and sending you to a hospital."

4. Review of the facility's "Code Blue (Resident found without vital signs)" policy, published November 2019, showed "...The resident's code status is established immediately by the nearest Licensed Nurse (LN) using the POLST/POST/Advance Directives...CPR is initiated by the LN for those residents who: a. Have requested, through advance directive or POLST/POST, to have CPR initiated when cardiac or respiratory arrest occurs. b. Have not formulated an advanced directive nor have a POLST in their medical record. c. Do not have a valid DNR order."

5. Review of the facility's "Advance Directive" policy, updated April 2023, showed "...The Center follows each advance directive that has been provided to it in accordance with State and Federal Law...In the absence of an Advanced Directive, the Center provides full treatment to the resident in the event of an emergency of health change.

6. On 5/2/24 at 8:30 AM the administrator was informed of the immediate jeopardy related to lack of CPR in accordance with advance directives.

7. The facility submitted a removal plan which included:

a. Education to all staff regarding POLST

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F 678	Continued From page 4 forms and code blue. b. 100% audit of all POLST forms for all current residents. c. Audit of all licensed nurses for verification of up to date CPR. e. A mock Code Blue drill was conducted on 5/2/24, and would occur on every shift for the next 24 hours. 8. The removal plan was accepted on 5/2/24 at 11:50 AM. 9. The implementation of the removal plan was verified and immediacy was removed on 5/2/24 at 12:34 PM; however, deficient practice remained at a scope and severity of "G."	F 678		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and physician interview, the facility failed to ensure the medication error rate was 5% or less. There were 2 errors out of 25 medications administered, for an error rate of 8%. The findings were: 1. Observation of RN #1 on 5/1/23 at 9 AM showed administration of folic acid 2 tablets of 400 mcg and 20 ml of liquid potassium to resident #24. Interview with the nurse at that time revealed the MAR showed the resident's order for folic acid	F 759	F759: 1) RN #1 was educated immediately by DNS related to medication administration. Resident #1 has medications administered without errors. The current medication error rate in Center is less than 5%. 2) Initial audit completed by DNS/Designee to assess for other medication errors and corrections made as necessary. 3) Education provided by DNS/Designee	5/26/24

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F 759	Continued From page 5 was 2-400 MG tablets and the folic acid was dispensed in micrograms (not milligrams) so she corrected the MAR from mg to mcg to prevent the error and gave a total of 800 mcg of folic acid to the resident. In addition, the potassium chloride bottle showed the concentration as 20 mEq/15 ml "give 20 ml's" and the nurse confirmed there was 20 ml in the resident's medication cup. 2. Review of the medication orders in resident #1's medical record showed an order for folic acid 400 mg tablets, 2 tablets, twice a day and for liquid potassium chloride 15 mEq with a concentration of 20 mEq/15 mls. 3. Interview with the ordering physician (physician #1) on 5/2/24 at 12:55 PM confirmed the order should have been written in mEq not mls; the pharmacy should have calculated the dose based on the concentration of the liquid (mEq/ml) and 20 ml was not equal to 15 mEq as ordered.	F 759	to licensed nurses related to medication errors, rights of medication pass, medication transcription, when and how to contact pharmacy for assistance and questions. New orders for current residents as well as orders for new admissions will be reviewed daily, times five days per week, times three months. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly times at least three months for further recommendations	
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	F 812		5/26/24

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F 812	Continued From page 6 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 Food Code, the facility failed to store and prepare food in accordance with professional standards related to expired food and cleanliness during 2 of 2 observations in the kitchen. The findings were: 1. Observation of the walk-in refrigerator on 4/29/24 at 2:54 PM showed two 5 pound containers of sour cream with an expiration date of 4/5/24 and another with an expiration date of 4/15/24. In addition there was a 5 pound container of cottage cheese with an expiration date of 4/15/24 and another with an expiration date of 4/19/14. Observation again on 5/2/24 at 1:31 PM with the dietary manager showed the expired food items were still there. Interview at that time with the dietary manager revealed staff usually looked through the refrigerator weekly for expired items. Review of the 2022 Food Code, US Food and Drug Administration, showed "...Except as specified in ¶¶ (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on	F 812	F812: 1) Walk in cooler, hanging pot/utensil rack, window fan, and fire extinguisher were cleaned per professional standards and current supplies were checked for expiration dates and opening dates by E.D./Designee. 2) Initial audit of current supplies completed by E.D./Designee to assess that other supply items are in compliance with professional standards. Initial audit completed by E.D./Designee to assess other storing, preparing, and/or distribution concerns with those corrected as needed. Initial audit completed by E.D./Designee to assess other cleaning concerns with those corrected as needed. 3) Education provided by E.D./Designee to dietary staff related to dating supplies upon receipt as well as when opening the product as well as stock rotation. Education related to kitchen cleaning schedule and expectations provided by E.D./Designee. Ongoing audits will be completed by E.D./Designee weekly times three months to assess proper storage, preparation, and distribution as well as cleanliness of kitchen. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly times at least three months for further recommendations.	

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F 812	Continued From page 7	F 812		

the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer ' s use-by date if the manufacturer determined the use-by date based on FOOD safety."

2. Observation on 5/1/24 at 5 PM in the kitchen showed the hanging pot/utensil rack had dust and dirt visible on the surface. At the time, there were 3 pots and 10 utensils hanging from the rack. In addition, the fan in the window above the spice rack and the fire extinguisher near the spice rack were both visibly dusty/dirty. During an interview on 5/2/24 at 1:31 PM the dietary manager stated the hanging pot holder was on the weekly cleaning schedule and the fan in the window was going to be removed.

Review of the 2022 Food Code, US Food and Drug Administration, showed "...4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."