STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG HORN REHABILITATION AND CARE CENTER	**1851 BIG HORN AVE SHERIDAN, WY 82801**

(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 9/10/24 to 9/13/24. Also reviewed in the course of the survey were complaint intakes WY00003899 and WY00003972. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant MA-C: Certified Medication Aide DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Sheet Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and	F 576		10/7/24

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

Electronically Signed | 10/04/2024

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F 576	Continued From page 1 (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure mail was delivered and unopened, including on Saturday. The census was 78. The findings were: 1. Interview with 5 residents during a group interview on 9/11/24 at 2 PM revealed the mail was "locked up" and the facility did not deliver mail on Saturdays. Further, the residents revealed mail was "sometimes opened" by the business office prior to delivery. 2. Interview with the activities director on 9/13/24 at 9:02 AM revealed she sorted through the mail	F 576	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN	

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F 576	Continued From page 2 and if it was not postcards or junk mail, she took it to the business office to open. Further, she revealed that mail was not delivered on Saturdays as the business office was closed. 3. Interview with business office manager on 9/13/24 at 10:20 AM revealed she was new to the facility and "still learning what to do with the mail." She revealed she opened the mail to decide where it should go as some would be scanned into the computer for the resident's file and bills for the residents were paid out of their account. She revealed "If it's personal mail it's opened here. Sometimes they get stressed over bills and they don't know what to do with them so we do that here." 4. Observation on 9/13/24 at 10:20 AM showed a stack of residents' mail on the desk in the business office.	F 576	SUBSTANTIAL COMPLIANCE WITH FEDERALREQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Residents are now receiving mail delivery including Saturdays and mail is unopened unless resident has required assistance. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Nursing Home Administrator/Designee audited process by asking residents about mail delivery on 9/20/2024 residents received all outstanding mail that was delivered to the facility, and are satisfied with the new process III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education will be provided to all staff 10/7/2024 regarding mail delivery. Mailbox check and delivery has been added to the Manager on Duty checklist for weekend manager.	

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F 576	Continued From page 3	F 576	IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED audit of process will be done weekly x 4 by Social Services/designee, Residents will also be asked at monthly resident councils x 3 to ensure they are receiving their mail timely. This will be used as x 4 week audit tool and a monthly audit tool. Results of these audits will be brought to monthly QAPI meetings to determine patterns, trends of concern, and/or if further education is needed. Frequency and continuation of audits will be determined/adjusted at that time.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		10/7/24

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F 578	Continued From page 4 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents choice for advance directive for 1 of 18 sample residents (#50). The findings were: 1. Review of the electronic medical record (EHR) "Clinical Resident Profile" for resident #50 on 9/12/24 at 8:02 AM showed "Code Status: (Advance Directives) ADC: Full Code." 2. Review of a physician's note for resident #50 dated 9/12/24 and timed 7:16 AM showed "...Code Status: ADC FULL CODE..." 3. Review of the physician orders for resident #50 showed an order for "ADC: Full Code" which was	F 578	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERALREQUIREMENTS OF	

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F 578	Continued From page 5 active with a start date of 7/24/24. 4. Review of the 8/14/24 "WyoPOLST-Providers Orders for Life Sustaining Treatment" signed by resident #50 showed "Cardiopulmonary Resuscitation (CPR)" was marked "DNR/Do Not Attempt Resuscitation (Allow Natural Death)." 5. Interview with the DON on 9/12/24 at 9 AM confirmed resident #50 had elected a code status of DNR and the EHR indicated Full code. Further interview revealed the facility should follow the resident's code status election.	F 578	PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #50 Polst information in Point click care was updated on day of survey -9/13/2024- to reflect residents wishes II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: By 10/4/2024 an audit of in-house residents was completed by Director of Nursing or designee verifying that POLST on file matches facility electronic charting designation. In-house residents that do not have current POLST on file or Advanced Directives will meet with Social Worker or designee and education on Advanced Directives provided. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Nursing staff were educated by Director of Nursing or designee starting 10/4/2024 on Advanced Directives and ensuring orders remain current and are updated	

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F 578	Continued From page 6	F 578	with changes as they occur. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED . Random audits will be completed by Director of Nursing or designee 3 times per week for 12 weeks or until substantial compliance maintained. Audit will include ensuring Advanced Directive available in chart and they match facility electronic charting. Results of audits will be brought to QAPI for review and recommendation	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or	F 645		10/7/24

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F 645	Continued From page 7 (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental	F 645		

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F 645	Continued From page 8 disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure preadmission screening was performed and was accurate for 2 of 18 sample residents (#8, #59) with qualifying diagnoses. The findings were: 1. Review of the quarterly MDS assessment dated 7/29/24 showed resident #8 had diagnoses which included depression and bipolar disease. Review of the resident's active diagnosis report showed the resident had diagnoses which included mood disorder due to known physiological condition with mixed features and did not have a primary diagnosis of dementia. The following concerns were identified: a. Review of the PASARR Level I assessment completed on 3/8/23 showed the resident had a qualifying diagnosis of mood disorder due to known physiological condition with mixed features and was marked "no" for all mental illness screening questions. Further review showed the PASARR Level I screening summary indicated no evidence of mental illness or intellectual disability. A PASARR level II was not triggered or performed. 2. Review of the admission MDS assessment dated 6/3/24 showed resident #59 had diagnoses which included depression and bipolar disease. The following concerns were identified:	F 645	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERALREQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #8 had a review screening done	

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F 645	Continued From page 9 a. Review of a PASARR level I completed on 5/23/24 showed the resident had diagnoses which included bipolar disorder and depression and the mental illness screening indicated the resident had a major mental illness. Further review showed the PASARR level I screening summary indicated a categorical 6 determination and the resident was appropriate for convalescent care after acute hospital stay, not to exceed 120 days. Additional information showed "...An individualized level II determination will be required on the 120th day if client stay will be extended, please plan accordingly." b. Review of a PASARR Level I completed on 7/3/24 showed the resident had diagnoses which included bipolar disorder and depression and was marked "no" for all mental illness screening questions. Further review showed the PASARR Level I screening Summary showed "No evidence of Mental Illness or Intellectual disability." 3. Interview with the administrator on 9/12/24 at 9:02 AM revealed the facility identified issues with duties performed by social services and the social services director was terminated. Further interview revealed PASARR completion was one of the duties assigned to the social services director. 4. Interview with the administrator on 9/12/24 at 10:58 AM revealed a plan to correct issues with PASARR completion was created; however, she confirmed it had not been implemented at that time. Further interview confirmed the most recent PASARR level I for resident #8 and resident #59 was not completed accurately.	F 645	by the MDS coordinator 9/20/2024 and now reflect correct PASARR Levels Resident #59 had review screening done by the MDS coordinator and on 9/13/2024 and now reflects correct PASARR Levels II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All Residents who triggered for a significant change, or received a new qualifying diagnosis for the past 90 days were also screened to ensure that any new diagnosis which require level II PASRR screening will have new screening completed as identified. current residents will be screened to identify any all diagnosis that require level II PASRR screening. Findings documented on audit tool. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Staff responsible for completing PASRR changes have been in-serviced on the new process for monitoring for PASRR changes. The process to complete application is as follows: A) Print resident current existing PASRR notification B) resident review of face sheet and diagnosis list. C) review of PASRR screen for listed diagnosis and condition list as required for review. D) Resubmittal	

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F 645	Continued From page 10	F 645	of PASRR screen based on current list of conditions. E) Review of care plan to ensure person centered care. F) upon new condition /new qualifying diagnosis review and resubmittal of PASRR. G) Update PASRR audit tool. Using the new process change, all identified residents will have a completed application submitted by 10/07/2024. Distribution of original screen by admission coordinator from Hospital/ acute setting prior to admission with diagnosis list review Review of diagnosis list SW, MDS, and PASRR screen submittal for any residents with mental health diagnosis (new admission or current admissions with new diagnosis). PASRR audit will be conducted by SSD or designee at quarterly care plan meetings to ensure new diagnosis that meets PASRR level II screening requirements are screened appropriately IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED Weekly audits will be conducted x4, monthly x3, and quarterly thereafter to monitor any activities that would require PASRR change, ie. Admissions, readmissions, significant changes and new dx of mental illness Findings of the audit tool will be address immediately through Inservice training and appropriate staff will submit application for PASRR change. Any and all negative findings identified will	

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F 645	Continued From page 11	F 645	be submitted to the QAPI committee monthly, and or changes will be made to this plan as deemed necessary by the committee.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident, resident representative, and staff interview, and medical record review, the facility failed to ensure residents received services to maintain good personal hygiene for 3 of 5 sample residents (#8, #25, #53) reviewed for activities of daily living. The findings were: 1. Review of the quarterly MDS assessment dated 7/29/24 showed resident #8 had a brief interview for mental status score of 15 out of 15, which indicated no cognitive impairment, and diagnoses which included polyneuropathy, cervicalgia or neck pain, osteoarthritis, and muscle wasting and atrophy. Further review showed the resident required substantial/maximal assistance with bathing. Review of the ADL (activities of daily living) care plan last revised on 4/8/24 showed "I have told staff I prefer to have my showers, but I often may refuse my showers and only get 1 a week. If staff if [sic] making up my shower it may not be on the day or time I originally chose, but I am ok with that...BATHING/SHOWERING: I need 1 staff to provide weight-bearing assistance for my shower	F 677	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERALREQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE	10/7/24

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	535026	A. BUILDING _____ B. WING _____	C 09/13/2024

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BIG HORN REHABILITATION AND CARE CENTER	1851 BIG HORN AVE SHERIDAN, WY 82801

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F 677	Continued From page 12 activities. Encourage me to perform any part of showering I am able..." The following concerns were identified: a. Interview with the resident on 9/11/24 at 11:07 AM revealed s/he did not receive showers routinely and s/he felt it was due to the facility not having enough staff. b. Review of the resident's bathing record from 6/29/24 through 9/12/24 showed the resident went without bathing for 6 days between 7/1/24 and 7/9/24, 14 days (including 3 documented refusals) between 7/9/24 and 7/24/24, 9 days between 7/29/24 and 8/8/24, 6 days between 8/12/24 and 8/19/24, 7 days between 8/23/24 and 8/29/24, and 14 days between 8/29/24 and 9/12/24. 2. Review of the quarterly MDS assessment dated 6/21/24 showed resident #25 had a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. Review of the care plan last revised on 6/22/24 showed the resident preferred to shower once a week in the morning. The following concerns were identified: a. Interview with the resident on 9/11/24 at 8:55 AM revealed "I'm supposed to get showers once a week. Yesterday was my two weeks and I didn't get any." b. Review of the 30-day look-back for the showers tasks showed the resident went 21 days without a shower from 8/6/24 to 8/27/24, and 15 days without a shower from 8/27/24 through 9/11/24. 3. Review of the quarterly MDS assessment dated 8/2/24 showed resident #53 had a BIMS score of 11 out of 15, which indicated the resident's cognition was moderately impaired. Review of the care plan last revised on 7/31/24	F 677	RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #8 received a shower on 09/13/2024, the date of survey and has been receiving showers regularly per preference since then, Resident #25 received a shower on 09/13/2024 and has been receiving showers per preference regularly since then. Resident #53 was given shower and hair washed on 09/13/2024 and has been receiving showers per preference regularly since then II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Quality Review audit on current residents residing in the facility to ensure activities of daily living completed to maintain good nutrition, grooming, and personal and oral hygiene was completed on 10/4/2024 by the Interdisciplinary team Issues or concerns were addressed as they were identified. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Director of Nurses//Designee re-educated the certified nursing aides and licensed nurses on the components of this	

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F 677	Continued From page 13 showed the resident preferred to take a shower two times a week during the day. The following concerns were identified: a. Interview with the resident on 9/10/24 at 3:36 PM revealed s/he was supposed to get two showers a week and "almost never did. I hear lots of excuses." b. Observation of the resident on 9/10/24 at 3:36 PM showed the resident was wheelchair bound and dependent on others for bathing. The resident's hair was greasy and nails were long. c. Review of the 30-day look back for the showers task showed the resident went 6 days without a shower from 9/5/24 to 9/11/24. 4. Interview with the resident representative for resident #47 on 9/11/24 at 4:15 PM revealed she had concerns about the amount of care residents received and stated the facility was "short-handed." 5. Interview with CNA #1 on 9/12/24 at 2:04 PM revealed the staffing levels were not sufficient enough to get resident care done. The CNA revealed she was expected to get showers done; however, she was unable to perform the showers. The CNA revealed showers were completed for residents when staff identified the residents had body odor and "really need a shower." Further interview revealed staff had voiced concerns to the leadership team and they were told "we are trying;" however, felt it was impossible to get all tasks done daily. 6. Interview with CNA #2 on 9/12/24 at 2:07 PM revealed getting "normal" care done was possible; however, she was not able to get showers completed. Further interview revealed sometimes they had a shower aide; however, she	F 677	regulation with an emphasis on ensuring activities of daily living completed to maintain good nutrition, grooming, and personal and oral hygiene by 10/04/2024. The Interdisciplinary team will complete frequent rounds on assigned rooms to ensure resident needs are being met. Newly hired certified nursing aides and licensed nurses will receive education in orientation. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED The Director of Nurses /designee will conduct a weekly audit of 5 residents weekly x 4 weeks, and then every 2 weeks x 2 months to ensure activities of daily living completed to maintain good nutrition, grooming, and personal and oral hygiene. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met and recommends moving to quarterly monitoring by the Director of Clinical Operations or Director of Compliance when completing their systems review.	

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F 677	Continued From page 14 wasn't at the facility daily and only worked 4 hours per day. 7. Interview with CNA #3 on 9/12/24 at 2:19 PM revealed there were not enough CNAs to ensure resident care was performed and CNAs were expected to provide ADL care including showers and making beds, taking meal orders, and picking up and passing room trays for meals. The CNA revealed showers were not completed often, beds are were not made, and linens were not changed as expected. 8. Interview with the DON and director of clinical operations on 9/12/24 at 1:17 PM revealed the facility identified concerns related to bathing and completed an ad hoc meeting on 9/3/24. The leadership team was to audit showers daily on the night shift, discuss the audit results in stand up, and clinical management was to follow up the next day. Further interview confirmed there were residents, including resident #8, who had not received showers prior to or following the ad hoc meeting.	F 677		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		10/7/24

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F 725	Continued From page 15 at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident, resident representative, and staff interviews, facility staff posting review, and facility assessment review, the facility failed to ensure sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident on 3 of 4 resident care units (Deer, Chapel, Courtyard). The census was 78. The findings were: 1. Observation on the Courtyard Hall (secure unit) on 9/10/24 at 5:10 PM showed MA-C #1 assisted resident #68 who stood up from a recliner and walked across the room. The MA-C attempted to get the resident to sit in his/her wheelchair; however, she was only able to sit the resident sideways in the seat and was unable to reposition the resident safely in the wheelchair. The MA-C required assistance from a second person, and attempted to call 5 people for assistance, which were not answered. Interview with the MA-C	F 725	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERALREQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND	

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F 725	Continued From page 16 revealed "this is how it always is." Continued observation showed at 5:16 PM an unidentified non-clinical staff member opened the secure unit door and the MA-C asked them to "get some help now!" At 5:17 PM (seven minutes later) a CNA arrived to assist and the staff member repositioned the resident in the wheelchair. 2. Observation of the Deer Hall on 9/12/24 at 8:54 AM showed resident #50 yelled from the bathroom "No one's coming in here! I've been waiting half an hour!" Review of the MDS assessment showed the resident's brief interview for mental status score was 15 out of 15 which indicated no cognitive impairment. 3. Interview with resident #8, who resided on the Chapel Hall, on 9/11/24 at 11:07 AM revealed s/he did not receive showers routinely and s/he felt it was due to the facility not having enough staff. Review of the resident's bathing record from 6/29/24 through 9/12/24 showed the resident went without bathing for 6 days between 7/1/24 and 7/9/24, 14 days (including 3 documented refusals) between 7/9/24 and 7/24/24, 9 days between 7/29/24 and 8/8/24, 6 days between 8/12/24 and 8/19/24, 7 days between 8/23/24 and 8/29/24, and 14 days between 8/29/24 and 9/12/24. 4. Interview with resident #25, who resided on the Deer Hall, on 9/11/24 at 8:55 AM revealed s/he was supposed to get showers once a week, and "yesterday was my two weeks and I didn't get any." Review of the 30-day look-back for the showers tasks showed the resident went 21 days without a shower from 8/6/24 through 8/27/24, and 15 days without a shower from 8/27/24 through 9/11/24.	F 725	SECTION 7317A OF THE STATE OPERATIONS MANUAL. I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Residents #68,50,8,25,53,and 10 have exhibited no ill effects from staffing. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The facility has conducted an audit on 09/18/2024 by the administrator to ensure that residents are receiving sufficient nursing staff to meet their needs. Scheduler will review staffing daily with Administrator/DON to ensure adequate staffing. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: the scheduler was educated by the Nursing home administrator on the RA job description as well as which employees hours should or should not be included in the daily staffing hours Education provided to facility staff on the attendance policy due to frequent call-ins creating insufficient staffing. Scheduler will complete a weekly audit to determine trends regarding call-ins until substantial compliance is maintained. Interdisciplinary	

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F 725	Continued From page 17 5. Interview with resident #53, who resided on the Deer Hall, on 9/10/24 at 3:36 PM revealed s/he did not receive two showers per week because of staffing. Observation of the resident at that time showed the resident's hair was greasy and his/her nails were long. Review of the 30-day look back for the showers task showed the resident went 6 days without a shower from 9/5/24 through 9/11/24. 6. Interview with the resident representative for resident #10, who resided on the Deer Hall, on 9/11/24 at 11:55 AM revealed when the representative was there to visit there were not a lot of staff to help and the representative had assisted the resident with meals. The representative reported it "could be several hours" before the resident received assistance. 7. Interview with resident #23, who resided on the Deer Hall, on 9/11/24 at 2 PM revealed that the facility had lost a lot of staff recently. Further interview revealed "nothing is getting done" after losing administrative staff. The resident also reported to have waited 30 minutes for call lights to be answered, and s/he missed a doctor's appointment as there was no van driver available. 8. Interview with the resident representative for resident #47, who resided on the Chapel Hall, on 9/11/24 at 4:15 PM revealed she had concerns about the amount of care residents received and stated the facility was "short-handed." 9. Interview with CNA #4, who worked on the Rock Creek Hall, on 9/12/24 at 1:57 PM revealed the facility continued admitting residents even though they didn't have sufficient staff to take	F 725	team was assigned rooms for Caring Partners, and they query residents daily regarding care and if their needs are being met. Any concerns identified are documented on a Quality Assistance Form. Scheduler will review staffing daily with Administrator/DON/or their designees to ensure adequate staffing. The facility has offered several different incentives to assist in acquiring and retaining qualified staff. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED Director of nurses/designee will conduct weekly audits on each unit to ensure that the facility has sufficient nursing staff with the appropriate competencies and skills to provide nursing services as required. Results of weekly audits will be submitted to QAPI Committee monthly. The Director of Nursing is responsible for sustained compliance .	

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F 725	Continued From page 18	F 725		

care of the residents already in the facility. The CNA revealed if there were more staff, they could better watch over residents who need closer observation.

10. Interview with CNA #1, who worked on the Deer Hall, on 9/12/24 at 2:04 PM revealed the staffing levels were not sufficient enough to get resident care done. The CNA revealed she was expected to get showers done; however, she was unable to perform the showers. The CNA revealed showers were completed for residents when staff identified the residents had body odor and "really need a shower." Further interview revealed staff had voiced concerns to the leadership team and they were told "we are trying;" however, felt it was impossible to get all tasks done daily.

11. Interview with CNA #2, who worked on the Deer Hall, on 9/12/24 at 2:07 PM revealed getting "normal" care done was possible; however, she was not able to get showers completed. Further interview revealed sometimes they had a shower aide; however, she wasn't at the facility daily and only worked 4 hours per day.

12. Interview with CNA #3, who worked on the Chapel Hall, on 9/12/24 at 2:19 PM revealed there were not enough CNAs to ensure resident care was performed and CNAs were expected to provide ADL care including showers and making beds, taking meal orders, and picking up and passing room trays for meals. The CNA revealed showers were not completed often, beds are were not made, and linens were not changed as expected.

13. Review of facility staff posting on 9/12/24 at

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F 725	Continued From page 19	F 725		

11 AM showed resident assistant (RA) hours were included in daily staffing hours. Review of the RA job description dated 1/20/23 showed "...the resident assistant/CNA trainee provides basic personal service to residents/patients under the direction and supervision of RN, LPN or LVN." Interview with staff scheduler on 9/13/24 at 9:39 AM revealed she was not sure if RA hours could be included in the daily staff hours, but she had included them.

14. Review of the revised facility assessment tool dated 8/6/24 showed the minimum hours per resident days (HPRD) for RN's/LPN's was 0.6 for both day and night shifts, CNAs on day shift was 1.0 and night shift was 0.9. HPRD for a total 2.0 HPRD.

15. Review of the July 2024 nursing schedule showed the facility failed to ensure the minimum staffing requirement identified on the facility assessment was met on 3 days, 7/22, 7/23, and 7/28.

16. Review of the August 2024 nursing schedule showed the facility failed to ensure the minimum staffing requirement identified on the facility assessment on 15 days, 8/1, 8/2, 8/3, 8/9, 8/10, 8/11, 8/12, 8/20, 8/21, 8/22, 8/23, 8/28, 8/29, 8/30, and 8/31.

17. Review of the September 2024 nursing schedule, from 9/1/24 through 9/12/24, showed the facility failed to ensure the minimum staffing requirement identified on the facility assessment was met on 5 days, 9/1, 9/2, 9/5, 9/8, and 9/9.

18. Interview with the administrator, DON, and staff scheduler on 9/13/24 at 9:39 AM confirmed

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F 725	Continued From page 20 the facility was aware of staffing concerns and revealed they recently had a lot of staff return to school or leave during a recent leadership turnover. The staff scheduler revealed she "usually" attempted "to stick to 2.75 and 2.92 combined HPRD total CNA's and RN/LPN's." They revealed they attempted to staff 24 hours per day for nurses and between 75 and 80 hours on day shift and 34 and 46 hours on night shift for CNAs. They revealed the current open positions included 2 full time day shift and 2 full time night shift nurses and 2 full time day shift and 4 or 5 full time night shift CNAs. Further interview revealed a lot of "nurse positions" were being covered by MA-Cs who help CNAs; however, they were not assigned to resident care and the MA-C hours were counted in the CNA hours on staff postings.	F 725		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		10/7/24

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F 761	Continued From page 21 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure medications available for resident use were labeled appropriately in 2 of 5 medication storage areas (Rock Creek Hall medication cart, Deer Hall medication cart). The findings were: 1. Observation of Rock Creek Hall medication administration cart on 9/10/24 at 4:16 PM showed a Novolog insulin pen which was opened and undated. In the top-drawer of the cart, yellow stickers were available for medication labeling. 2. Observation of the Rock Creek Hall medication cart on 9/11/24 at 10 AM showed a Lantus SoloStar insulin pen and Toujeo SoloStar multidose insulin pen which were opened and undated. In the top-drawer of the cart, yellow stickers were available for medication labeling. 3. Observation of the Deer hall medication cart on 9/11/24 at 09:55 AM showed a Basaglar insulin pen which was opened and undated. In the top-drawer of the cart, yellow stickers were available for medication labeling. 4. Interview with the LPN #1 on 9/10/24 at 4:16 PM revealed she did not open the insulin pen and a yellow sticker should have been placed to indicate when the medication was opened, when	F 761	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERALREQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE The Novolog insulin pen, The Lantus Solostar pen, the Toujeo Solostar	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 09/13/2024

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F 761	Continued From page 22 it would expire, and who opened it. 5. Interview with LPN #2 on 9/11/24 at 10 AM revealed all insulin pens should be labeled with a yellow sticker, dated with an open date and expiration date, and initialed. Further she revealed all insulin pens should be discarded after 28 days from the open date. 6. Interview with the DON on 9/13/24 at 8:23 AM revealed all nurses were responsible for labeling and dating multidose vials of medication upon opening. Further he revealed the nurses were also responsible for indicating the 28-day expiration date on the yellow labels, along with their initials. 7. Review of the policy titled "Labeling of Medications and Biologicals" dated 4/16/24 showed "...Labels for multidose vials must include: the date the vial was initially opened or accessed (needle-punctured) ..."	F 761	multidose insulin pen and the Basaglar insulin pen were all disposed of appropriately and re-ordered with no delay in service. There were no residents listed that were affected by this practice. All residents have the potential to be affected. All medication carts and refrigerators for all units were audited to determine if any further medications were found to be stored past their expiration dates on 09/20/2024. Any medications that were found to be past their expiration dates were disposed of appropriately. On 9/16/2024 the licensed nurses were educated by the Staff Development Coordinator, Director of Nursing, or Unit Managers on the Storage and Labeling of Medications Policy. An audit of each medication cart and medication refrigerators will be completed weekly for a month and then monthly for two months to identify if any issues are noted with labeling of medications and/or expiration dates. The results of the audits will be presented to the Quality Assurance and Performance Improvement Committee by the Director of Nursing Services for 3 months then as needed. The Quality Assurance Performance Improvement Committee will then determine if any further actions, systematic changes, or monitoring is needed to assure sustained compliance.	

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F 761	Continued From page 23	F 761	II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All medication carts and refrigerators for all units were audited by the Director of Nursing/designee to determine if any Insulin pens were found to be stored past their expiration dates (28 days) or not labeled properly on 09/20/2024. Any medications that were found to be past their expiration dates or not labeled appropriately were disposed of appropriately, at that time. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 09/16/2024 the licensed nurses were educated by the Staff Development Coordinator, Director of Nursing, or Unit Managers on the Storage and Labeling of Medications Policy. An audit of each medication cart and medication refrigerators will be completed weekly for a month and then monthly for two months to identify if any issues are noted with labeling of medications and/or expiration dates. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED	

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F 761	Continued From page 24	F 761	Director of Nurses/Designee will conduct weekly audits on each unit x 3 months to ensure that the facility has sufficient nursing staff with the appropriate competencies and skills to provide nursing services as required. Results of weekly audits will be submitted to QAPI Committee monthly, with decision made by team to continue if needed. The Director of Nursing is responsible for sustained compliance	