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	535017	A. BUILDING _____ B. WING _____	06/12/2025

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/9/25 through 6/12/25. Also reviewed in the course of the survey were complaint intakes WY00004412 and WY00004413. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant MDS: Minimum Data Set mg: milligrams RAI: Resident Assessment Instrument Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,	F 605		7/11/25

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

Electronically Signed | 07/05/2025

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F 605	Continued From page 1	F 605		

involuntary seclusion and any
physical or chemical restraint not required to treat the resident's medical
symptoms.
§483.12(a) The facility must-. . .
§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints
imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.
. . . .
§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.

§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-
(1) In excessive dose (including duplicate drug therapy); or
(2) For excessive duration; or
(3) Without adequate monitoring; or
(4) Without adequate indications for its use; or
(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the

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F 605	Continued From page 2 facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure adequate monitoring of psychotropic	F 605	The facility failed to ensure adequate monitoring of psychotropic medications for 2 of 6 sample residents (#2, #90)	

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F 605	Continued From page 3 medications for 2 of 6 sample residents (#2, #90) reviewed for unnecessary medications. In addition, the facility failed to ensure as needed (PRN) psychotropic medications were limited to 14 days unless there was a documented rationale for 1 of 6 sample residents (#89) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated 2/28/25 showed resident #2 had diagnoses which included non-Alzheimer's dementia, anxiety disorder, and depression. Review of the physician orders showed the resident had an order for duloxetine (antidepressant) 60 mg daily. The following concern was identified: a. Review of the medical record showed there were no identified target symptoms for the antidepressant. 2. Review of the medical record for resident #90 showed the resident admitted on 6/5/25 and had diagnoses which included disorientation, history of falling, and depression. Review of the resident's physician orders showed the resident had orders for mirtazipine (antidepressant) 7.5 mg and citalopram (antidepressant) 10 mg. The following concerns were identified: a. Review of the medical record showed no evidence the facility had identified or was monitoring target symptoms for the either antidepressant medication. 3. Review of the medical record showed resident #89 admitted to the facility on 5/23/25 with diagnoses which included dementia with psychotic disturbance, depression, and personal history or suicidal behavior. Review of the resident's physician orders showed an order for trazadone 50 mg PRN which was ordered on	F 605	reviewed for unnecessary medications. In addition, the facility failed to ensure as needed (PRN) psychotropic medications were limited to 14 days unless there was a documented rationale for 1 of 6 sample residents (#89) reviewed for unnecessary medications. To correct the deficient practice, the facility: A. For resident #2, who was identified as receiving an anti-depressant without identified target symptoms, the consent form was changed from diagnosis based documentation to symptom based documentation. Further, symptom/behavior tracking was added to resident #2's medication administration record to ensure tracking by qualified staff. To identify and correct the deficient practice for all other residents, an audit was conducted for residents who are receiving an anti-depressant or other psychotropic medication. This audit reviewed the medical record for compliance requirements of symptom tracking. Consents were changed where necessary and target symptom/behavior tracking was added to the medication administration record for all residents who were identified as needing individualized target symptom tracking based on medication orders. To prevent continued deficient practice, the facility provided nursing staff education at a clinical practice meeting on 07/02/2025. All physicians practicing in	

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F 605	Continued From page 4 6/9/25 and there was no stop date indicated. The following concerns were identified: a. Review of the medical record showed no evidence the physician provided a rationale for the PRN trazadone to not have a stop date. 4. Interview with the facility administrator on 6/12/25 at 9:02 AM confirmed some medications only have diagnosis and the facility did not identify target symptoms. Further she confirmed the physician did not provide a rationale for not indicating stop dates for the prn psychotropic medications. 5. Review of the facility policy titled "Psychotropic Utilization" last reviewed 2/14/25 showed "... (4) PRN orders for psychotropic 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...Medication Management:..The regulations associated with medication management include consideration of:.. adequate monitoring for efficacy and adverse consequences...Monitoring for Efficacy and Adverse Consequences...Monitoring and accurate documentation of the resident's response to any medication(s) is essential to evaluate the ongoing benefits as well as risks of various medications. Monitoring should also include evaluation of the effectiveness of non-pharmacological approaches, such as prior to administering PRN medications..."	F 605	the facility were provided education on both CMS and organizational policy requirements for psychotropic medication prescribing by the administrator and medical director prior to 07/03/2025. The Director of Nursing accepted responsibility for initiating and tracking individualized target symptom monitoring for residents on psychotropic medications. The Director of Nursing will report on the required compliance for psychotropic medications at the monthly pharmacy meeting and further report on compliance regarding individualized symptom tracking as a function of the facility's regularly scheduled QAPI meetings. B. For resident #90, who was identified as receiving an anti-depressant without identified target symptoms, the consent form was changed from diagnosis based documentation to symptom based documentation. Further, symptom/behavior tracking was added to resident #90's medication administration record to ensure tracking by qualified staff. To identify and correct the deficient practice for all other residents, an audit was conducted for residents who are receiving an anti-depressant or other psychotropic medication. This audit reviewed the medical record for compliance requirements of symptom tracking. Consents were changed where necessary and target symptom/behavior tracking was added to the medication administration record for all residents who were identified as needing individualized	

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F 605	Continued From page 5	F 605	target symptom tracking based on medication orders. To prevent continued deficient practice, the facility provided nursing staff education at a clinical practice meeting on 07/02/2025. All physicians practicing in the facility were provided education on both CMS and organizational policy requirements for psychotropic medication prescribing by the administrator and medical director prior to 07/03/2025. The Director of Nursing accepted responsibility for initiating and tracking individualized target symptom monitoring for residents on psychotropic medications. The Director of Nursing will report on the required compliance for psychotropic medications at the monthly pharmacy meeting and further report on compliance regarding individualized symptom tracking as a function of the facility's regularly scheduled QAPI meetings. C. With regards to resident #89 who showed an order for trazadone 50mg PRN without a stop date: To correct the deficient practice for resident #89, a stop date was immediately entered into the medication administration record. To identify and correct the deficient practice for all other residents, an audit was conducted on 06/27/2025 and 06/30/2025 to ensure any resident who had orders for PRN psychotropic medications also had stop dates for those medications. To prevent continued deficient practice, procedures allowing nursing staff to put in	

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F 605	Continued From page 6	F 605	a 14 day stop date for all PRN psychotropic medication, unless prohibited and documented by physicians, were initiated. Further, nursing staff was educated at a clinical staff meeting on 07/02/2025 regarding the regulation and need for stop dates on all PRN psychotropic medications. The Director of Nursing will report on PRN medications and stop dates at the monthly pharmacy meeting. The Director of Nursing will also report on compliance for stop dates on PRN psychotropic medications as a function of the facility's regularly scheduled QAPI meetings.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640		7/11/25

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F 640	Continued From page 7 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI manual review, the facility failed to ensure MDS assessments were transmitted within 7 days of completion for 1 of 15 sample residents (#3) reviewed. The findings were: 1. Review of a progress note for resident #3 dated 2/6/25 and timed 10:03 AM showed the resident expired at the facility. Review of the MDS	F 640	The facility failed to ensure MDS assessments were transmitted within 7 days of completion for 1 of 15 sample residents (#3) reviewed. To correct the deficient practice for resident #3, the MDS coordinator submitted the death in facility assessment on 06/10/2025.	

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F 640	Continued From page 8 data for the resident showed the discharge assessment had been completed; however, it had not been submitted. 2. Interview with the MDS coordinator on 6/10/25 at 3:36 PM confirmed the resident was discharged from the facility in February 2025, the assessment had been completed, and the assessment had not been transmitted. Further interview revealed she transmitted the assessment at that time. Further interview confirmed it should have been submitted prior. 3. Review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 dated October 2024 showed "...Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 +14 days for Entry records and A2000 + 14 days for Death in Facility records) ..."	F 640	To identify and correct potential deficient practice for all residents, the MDS coordinator completed an audit of all MDS's completed to ensure submission of the assessment occurred. This audit will be completed prior to 07/11/2025. Any resident assessments identified as needing submission will have that requirement met prior to 07/11/2025. To prevent continued deficient practice, the MDS coordinator was provided education regarding the late submission and regulatory requirements. The MDS coordinator will monitor assessments every 14 days to ensure all completed assessments have been submitted. The MDS coordinator will report on encoding and transmitting requirements as a function of the facility's regularly scheduled QAPI meetings.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/11/25

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F 880	Continued From page 9 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 10 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure proper infection control practices for 1 of 2 sample residents (#10) with foley catheter placement and during 2 meal observations. The census was 35. The findings were: Regarding residents with foley catheters: 1. Review of the quarterly MDS assessment dated 5/20/25 showed resident #10 had a brief interview for mental status score of 13 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included neurogenic bladder, diabetes mellitus, and dementia. Further review showed the resident required substantial/maximal assistance with toileting, showers, upper body dress, lower body dress, putting on footwear, and personal hygiene and had an indwelling urinary catheter. Review of the resident's care plan dated 3/13/25 showed "Problem: NURSING: Resident requires a suprapubic catheter related to neurogenic bladder with history of UTI" and the interventions included	F 880	The facility failed to ensure proper infection control practices for 1 of 2 sample residents (#10) with Foley catheter placement and during 2 meal observations. To address the deficient practices, the facility has implemented the following: A. Regarding resident #10, who was identified as lacking a barrier between the urinary catheter bag and the floor, the urinary catheter bag was placed in a wash basin beside the recliner on 06/09/2025. To identify and correct deficient practice for all residents, and audit was conducted on 06/09/2025 at 2100. Any urinary catheter bags noted on the floor were immediately placed in wash basins. To prevent further deficient practice, education regarding infection prevention policies and standards for urinary catheters was provided on 06/09/2025 at 2100. Repeat education was provided on 06/10/2025 at 0900 to ensure all shifts received immediate education. All nursing	

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F 880	Continued From page 11 "Cath to be emptied every 4 hours with resident checked for incontinent bowel during each encounter to prevent increased risk for infection. Cath care every shift & PRN [as needed] ...Do not allow tubing or any part of the drainage system to touch the floor..."The following concern was identified: a. Observation on 6/9/25 at 7 PM showed the resident was sitting in the recliner with his/her leg rest up. Under the leg rest, the urinary catheter bag was lying directly on the floor. No barrier was seen between the bag and floor and dark yellow urine was noted in the bag and in the catheter tubing. 2. Interview with CNA #1 on 6/10/25 at 3:38 PM revealed the urinary drainage bag was to be in a basin, and never on the floor. 3. Interview with the infection preventionist on 6/11/25 at 11:25 AM revealed it was the facility expectation for the urinary drainage bags to never be on the floor and to be covered. 4. Review of the procedure "Care of an indwelling Catheter" hand delivered on 6/11/25 at 11:30 AM by the infection preventionist showed "...9. ...g. Ensure drainage bag is secure in an opaque bag or wash basin. Bags may not rest on the floor or remain uncovered." Regarding meal service: 1. Observation on 6/10/25 at 7:59 AM staff member #1 was assisting with passing resident meal trays. While passing the trays, the staff member was observed touching residents' arms and wheelchairs. Without performing hand hygiene, the staff member approached a resident	F 880	staff were provided further education at the monthly clinical staff meeting on 07/02/2025, and written notification was placed in the nursing staff communication book. The infection control preventionist will conduct regular audits to ensure that urinary drainage bag are maintained in compliance with both CMS regulations and established facility policy. The infection control preventionist will report as a function of the facility's regularly scheduled QAPI meetings. Regarding meal service: A. To correct the deficient infection control practice identified during tray set up, staff member #1 was provided education regarding appropriate infection control practices and meal tray assistance on 06/10/2025. To identify and correct deficient practice for all residents, the infection control preventionist continues to monitor meal service regularly and provides education at point of need. To prevent continued deficient practice, all nursing staff were provided education at the monthly clinical staff meeting on 07/02/2025 as well as providing written education in the established nursing communication book. The ICP will continue to monitor for deficient meal service practices and report on the findings as a function of the facility's regularly scheduled QAPI meetings.	

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SUBLETTE COUNTY HEALTH	333 N BRIDGER AVE PINEDALE, WY 82941

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F 880	Continued From page 12 and assisted the resident by using her ungloved left hand to hold the resident's toast and applying butter with a knife in her right hand. 2. Observation on 6/11/25 at 11:53 AM showed dietary staff member #1, who was wearing gloves, rubbed his face with his left hand. Without removing the gloves, the staff member held the bun of a sandwich using his left hand, and cut the sandwich in half. 3. Interview with the infection preventionist on 6/12/25 at 10:43 AM revealed if staff were touching residents' food items, hand hygiene should be performed before contact with the food items and gloves were to be worn. Further interview revealed after staff touched contaminated surfaces, contaminated gloves should be doffed, hand hygiene should be performed, and new gloves should be donned. 4. Review of the facility policy titled "Hand Hygiene" last reviewed on 1/23/25 showed "...A. Indications for hand hygiene included: 1. Before touching a patient or resident...4. After touching a patient or resident...11. After contact with inanimate surfaces and objects in the immediate vicinity of the patient or resident... 14. After blowing or wiping the nose, coughing, or sneezing, even if a tissue is used..."	F 880	B. To correct the deficient infection control practice identified during meal service, education was provided to dietary staff member #1 regarding appropriate infection control practices and meal service on 06/11/2025. To identify and correct deficient practice for all residents, the CDM and infection control preventionist provided education to all dietary staff regarding appropriate meal service procedures. To prevent continued deficient practice, the dietary manager, registered dietician and infection control preventionist continue to audit meal service and provide education at any identified point of need. The ICP will continue to monitor and report as a function of the facility's regularly scheduled QAPI meetings.	