STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crook County Medical Services District Long Term Care	**713 Oak St , Sundance, Wyoming, 82729**

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F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/11/25 through 8/14/25. Also reviewed in the course of the survey was complaint intake: WY00004189 (1901991). The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse IP: Infection Preventionist MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F0000		09/01/2025
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F0700	Staff will obtain the following information before instillation of any side rails: resident will be assessed for risk for entrapment, appropriate dimensions, and manufacturers' recommendations and specifications for installing and maintaining bed rails. 1). Resident rooms will be checked weekly by the DON or designee for side rails that have not been approved through the proper process. They will be checked 1x a week x 6 weeks then monthly starting the week of 9/1/2025. 2). If a resident requests side rails, the appropriate process will be followed. The resident assessment and consent will be completed. 3). The side rails will not be used as restraints.	09/17/2025

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 reverse for further 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.

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

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F0700 SS = D	Continued from page 1 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure a safety assessment, including entrapment risk, of bedrails was completed for 1 of 5 sample residents (#21). The findings were: 1. Review of the quarterly MDS assessment dated 7/24/25 showed resident #21 had diagnoses which included cerebrovascular accident, and a BIMS score of 8 out of 15, which indicated moderate cognitive impairment. Interview with the DON on 8/13/25 at 2:39 PM confirmed there should have been a safety assessment for the bedrails. The following concerns were identified: a. Observation on 8/11/25 at 4:42 PM showed resident #21 had bilateral bed canes built into the frame of his/her bed. b. Review of the resident's medical record showed no evidence a bedrail assessment, which included entrapment risks, had been completed. c. Interview with resident #21 on 8/13/25 at 3:15 PM revealed s/he used the bedrails for positioning. 2. Review of the policy "Proper use of Bed Rails" provided by the DON on 8/14/25 at 8:24 AM and last updated 4/29/25 showed "...vi. A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail..."	F0700	Continued from page 1 4). Education regarding side rail use will be provided at the staff meeting at 9/3/2025 and annually. 5). Side rail use education will be added to the facility admission packet to help educate families. The facility policy will also be added to the admission packet. 6). Results of the side rail audits will be reviewed at the November 2025 QAPI meeting or PRN. If necessary, a QAPI meeting will be called to discuss an alternative plan to address this issue. 7). Residents with approved side rails have to be re-assessed quarterly, annually and with significant changes. 8). Resident #21 was assessed for side rail use, and it has been determined she is appropriate to use the rails for positioning. a consent was obtained. REJECTION RESPONSE Rejection Comments POC is not specific to resident #21. I spoke with the DON on 9/15/25. Marabeth Kopp	
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.-	F0727	The DON or Designee will review the schedule for accuracy of RN 8 Hrs/7 days Week & Full Time DON. The DON or Designee will monitor the schedule and identify where an RN is not placed on the schedule 8 hours a day, 7 days a week. This will be accomplished by a review of the schedule posted on SHIFTS.	09/03/2025

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F0727 SS = F	Continued from page 2 §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on staff schedule review, payroll based journal (PBJ) review, and staff interview, the facility failed to ensure an RN was on duty for 8 consecutive hours per day, 7 days per week during 1 of 4 quarters reviewed (1st quarter of fiscal year 2025). The census was 27. The findings were: 1. Review of the "PBJ Staffing Data Report" for quarter 1 of fiscal year 2025 (October 1,2024 through December 31, 2025) showed there was no RN on duty for 8 consecutive hours for 2 days in November 2024, 11/9 and 11/23. Further review showed there was no RN on duty for 8 consecutive hours for 5 days in December 2024, 12/7, 12/14, 12/21, 12/22, and 12/29: 2. Review of the staff schedule for November and December of 2024 confirmed there were no RNs on duty for 8 consecutive hours on 11/9, 11/23, 12/7, 12/14, 12/21, 12/22, and 12/29. 3. Interview with the DON on 8/14/25 at 10:46 AM	F0727	Continued from page 2 The DON is full time at 40 hours a week and will remain at 40 hours a week. 1) The schedule is posted at least 2 weeks in advance. 2) The schedule will be reviewed 3x a week x 6 weeks until October 14, 2025, then weekly, prior to the schedule being posted. This process began 9/1/2025. 3). The results of the audits will be reviewed at the QAPI Committee Meeting in November and PRN if the process reveals a need for more in-depth process improvement planning. 4). Any needed corrective action needed will be addressed upon discovery. 5). Education regarding FO727 will be reviewed at the 09/03/2025 staff meeting, annually and PRN.	

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F0727 SS = F	Continued from page 3 confirmed the facility did not have RN coverage 7 days a week for at least 8 consecutive hours a day on the days identified.	F0727		
F0880 SS = D	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: §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	F0880	The facility will ensure Infection Prevention standards are met through proper hand hygiene in the dining room when assisting residents with meals. This will be reflected by the following: 1). An updated Hand Hygiene Policy was that includes, "the following is a list of some situations that require hand hygiene: after caring for residents/patients, when changing gloves, between cares, between handling of resident/patient food/trays, between handling medications of different residents/patients, upon entrance and exit of a resident/patient room." 2). Staff education will be provided at the staff meeting 9/3/2025. The policy will be reviewed. Staff will be/have been educated by the Infection Control Nurse to sanitize their hands after touching equipment such as foot pedals before going back to feeding the resident. 3). Dining room monitoring for infection control practices will be done by the DON or designee starting 9/1/2025. Monitoring will be done 3x a week x6 week then weekly until the end of the year. 4). The monitor results will be reviewed at the QAPI meeting in November 2025 or before if the monitoring is showing the need for a more effective approach. In this case a QAPI meeting will be called to plan new interventions. 5). Corrective action and education will be provided during the audits when needed to enforce the safe and sanitary environment the goal the facility is striving to achieve. 6). Education will be provided annually and PRN. The facility will ensure safe and sanitary practices regarding use of urinary catheter bags. This will be reflected by the following.	09/03/2025

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F0880 SS = D	Continued from page 4 (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. §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 observations, staff interview, policy and procedure review, the facility failed to ensure infection prevention was maintained in 1 of 2 dining observations and 1 of 4 residents (#22) with urinary catheter observations. The findings were: Regarding urinary catheter drainage bags: 1. Observation on 8/13/25 at 2:15 PM showed LPN #1 and LPN #2 entered resident #22's room and the resident's catheter drainage bag was positioned on the floor at the foot of the bed, without a cover or other type of protection. Interview with LPN #2, at that time, revealed the facility expected the bag to not be on the floor and to be covered. 2. Interview with the IP on 8/14/25 at 9:32 AM revealed the expectation was for the urinary catheter drainage bag to be positioned below the bladder and covered. She	F0880	Continued from page 4 1). Implementation of an updated and approved Catheter Care Policy. 2). Observation of staff performing catheter care 3x a week x6 weeks, then weekly until the end of the year. This will include placement of the catheter when the resident is being transferred, when in bed and when in the wheelchair. 3). Staff education to be provided at the 9/3/2025 staff meeting regarding catheter care, care of the catheter bags, placement of the catheter bags and use of the privacy covers. 4). Results of the audits will be reviewed at the QAPI meeting in November 2025 or before if staff are failing to meet the standard of care. 5). Corrective action and education will be provided during the audits when needed to enforce the safe and sanitary environment goal the facility is striving to achieve. 6). Education will be provided yearly at annual training and PRN.	

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F0880 SS = D	Continued from page 5 confirmed the bag should not be placed on the floor, and there were basins provided to prevent placement of the bag on the floor. 3. Review of a education form "Proper Catheter Care for CNAs" hand delivered on 8/14/25 at 8:25 AM by the DON showed "...General Guidelines ...Ensure the drainage bag is securely attached to the bed frame or chair - never place it on the floor. We have fabric bags for this but can put plastic basins on floor if needed..." Regarding hand hygiene in the dining room: 1.Observation on 8/11/25 beginning at 5:39 PM showed CNA #1 assisted residents to eat at the assisted dining table. The CNA provided a bite of food to resident #25 who was sitting on her right, and then she turned to the resident on her left, adjusted the footrests, placed the resident's feet on the footrests, repositioned the resident in the wheelchair, and then provided additional bites of food to resident #25 without performing hand hygiene. 2. Interview with the IP on 8/14/25 at 9:41 AM confirmed hand hygiene should be performed between tasks. 3. Review of policy titled "Hand Hygiene" and last revised 4/2022, showed "...Hand hygiene continues to be the primary means of preventing the transmission of infection..."	F0880		