DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535027	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER: **Cody Regional Health Long Term Care Center**		STREET ADDRESS, CITY, STATE, ZIP CODE: **707 Sheridan Ave , Cody, Wyoming, 82414**	

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F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 4/6/26 through 4/9/26. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse SSD: Social Services Director SDC: Staff Development Coordinator MDS: Minimum Data Set BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0800 SS = F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and menu and alternative menu review, the facility failed to consider resident preferences for meals in 2 of 2 dining rooms (main dining room, 2nd floor dining room). The census was 51. The findings were:	F0800	1. Resident#_7, 36, 10, and 43 was interviewed regarding food preferences and the resident's Comprehensive Care Plan and Diet Card were reviewed to ensure they reflect the resident's preferences. 2. All residents have the potential to be affected when they do not want the main menu item. All available meal alternates will be posted in the dining rooms for residents to choose from and staff to reference. All other residents' care plans and diet cards were reviewed to verify they have preferences listed. 3. A meal preference form was created for staff to document the resident's choice for each meal, including alternate dishes that are available for the resident to choose from. All dietary and nursing staff were in-serviced regarding the requirement to offer an alternate dish from the available alternate menu	04/30/2026

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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F0800 SS = F	Continued from page 1 1. Interview with resident #7 on 4/6/26 at 4:05 PM revealed residents were not offered choices for meals and they "get what is served." S/he revealed residents could choose an alternative sandwich to eat if they did not want the main meal. 2. Interview with resident #36 on 4/6/26 at 4:41 PM revealed s/he did not feel she could make choices at the facility and there were not alternative meal options given if s/he did not like the food. 3. Observation of meal service in the second-floor dining room on 4/6/26 at 5:02 PM showed the white board indicated the dinner was a turkey and cheddar wrap with lettuce, tomato, and onion, garlic Brussel sprouts, and banana cream pie. There was no evidence of an alternative meal item listed. Interview with dietary staff member #1 at that time revealed if residents did not want the meal, the alternatives were always "different types of sandwiches." The staff member revealed there was not any additional alternative menu items. 4. Interview with resident #10 on 4/7/26 at 9:04 AM revealed residents were able to get sandwiches as an alternative meal and there were no other alternatives available. 5. Observation of meal service in the main dining room on 4/7/26 at 12:05 PM showed dietary staff member #2 asked staff member #1 what she should prepare for resident #43. Staff member #1 stated "I would make a sandwich for [him/her]." Without providing resident #43 a choice in his/her meal, the dietary staff member made a turkey sandwich with provolone cheese and chips, and gave it to the other staff member to deliver. Continued observation showed an unidentified CNA told dietary staff member an unidentified resident wanted a ground beef sandwich. The dietary staff member indicated she did not have ground beef, but the had chicken salad instead. The CNA stated "Yeah, give [him/her] chicken salad. That should be fine." The dietary staff member made the sandwich and gave it to the CNA to deliver without offering an alternative or an option that was available. 6. Observation of meal service in the main dining room on 4/7/26 at 12:21 PM showed a staff member was going around to each table and telling the residents what the meal was. The staff member	F0800	Continued from page 1 to any resident who declines the main dish. 4. The Nutrition Services Director or designee will conduct observations of 2 meals per week for 4 weeks to verify residents were offered alternates from the menu if they declined the main dish. Residents will be asked at each resident council meeting if they are offered a variety of alternate items at meals if they don’t want the main dish. 5. Results of audits will be reported by the DON or designee to the QAPI Committee for the next 4 months. Additional training and/or audits will be instituted as appropriate to ensure ongoing compliance.	04/30/2026

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F0800 SS = F	Continued from page 2 would then ask if the meal sounded good or if the resident would like a sandwich. No additional meal alternatives were offered. 7. Review of the facility menu showed there was one meal option posted daily; however, review of the alternative menu showed additional items were available for residents to request at all meals. The alternative menu included entrees and sides for breakfast alternatives and salads, soups, deli items, entrees, accompaniments, "from the grill," and desserts for lunch and dinner alternatives. 8. Interview with the dietitian on 4/7/26 at 4:46 PM revealed residents should be offered alternative items if they do not like or want the meal that was being served. She revealed alternative items available at all times included sandwiches, pizza, burgers, and anything else available from the grill. She revealed staff should not make decisions for residents without offering alternative items.	F0800		04/30/2026
F0605 SS = E	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, involuntary seclusion and any physical or chemical restraint not required to treat	F0605	1. Resident #'s 2, 4, 5, 41, and 56 were identified as being affected. All identified residents were reviewed and target symptoms for each medication were added to their Medication Administration Records (MAR) and tasks. In addition, the provider for each of the identified residents reviewed their prescribed psychoactive medications and documented identified targeted symptoms for each medication in the Electronic Medical Record (EMR). 2. All other residents receiving psychoactive medications were reviewed to ensure targeted symptoms were documented on the Medication Administration Records (MAR's) and Certified Nurse Aid (CNA) documentation tasks in their EMR and provider documentation included targeted symptoms for each medication. 3. Providers, licensed nurses and CNA's will be educated on ensuring documentation of targeted symptoms for each psychoactive medication is entered into the EMR on the MAR's, tasks and provider notes. 4. The Director of Nursing (DON) or designee will audit 5 records per week for the next 60 days of residents receiving psychoactive medications to verify targeted symptoms are documented correctly. 5. Results of audits will be reported by the DON or designee to the QAPI Committee for the next 4 months. Additional training and/or audits will be	04/30/2026

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F0605 SS = E	Continued from page 3 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 facility must ensure that--	F0605	Continued from page 3 instituted as appropriate to ensure ongoing compliance.	04/30/2026

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F0605 SS = E	Continued from page 4 §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 medications for 5 of 5 sample residents (#2, #4, #5, #41, #56) reviewed for unnecessary medications. The findings were: 1. Review of the quarterly MDS assessment dated 3/24/26 showed resident #41 had a BIMS score of 11 out 15, which indicated moderate cognitive impairment, and diagnoses which included anxiety disorder and depression. Further review showed the resident displayed no behaviors and received antidepressant and hypnotic medication. Review of the physician orders showed the resident received temazepam (hypnotic) 7.5 milligrams (mg) by mouth daily at bedtime for insomnia and duloxetine (antidepressant) 40 mg by mouth twice per day for	F0605		04/30/2026

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F0605 SS = E	Continued from page 5 major depressive disorder. Review of the antidepressant medication care plan, last revised on 3/31/26 showed interventions which included "Monitor/Document side effects and effectiveness Q [every] shift." The following concern was identified: a. Review of the medical record showed there were no resident specific or medication specific target symptoms identified or monitored for the use of temazepam or duloxetine. 2. Review of the admission MDS assessment dated 1/12/26 showed resident #2 had a BIMS score of 12 out of 15, which indicated the resident was cognitively intact, and diagnoses which included depression. Further review showed the resident displayed no behaviors and received antidepressant medication. Review of the physician orders showed the resident received duloxetine (antidepressant) 20 mg mouth daily for rheumatoid arthritis and depressive disorders and trazadone (antidepressant) 50 mg by mouth daily for insomnia. Review of the antidepressant medication care plan, last revised on 1/27/26 showed interventions which included "Monitor/Document side effects and effectiveness Q shift." The following concern was identified: a. Review of the medical record showed there were no resident specific or medication specific target symptoms identified or monitored for the use of duloxetine or trazadone. 3. Review of the medical record showed resident #56 admitted to the facility on 4/1/26 with diagnoses which included depression. Review of the physician's orders showed the resident received Adderall (amphetamine-dextroamphetamine) 20 mg by mouth twice a day for hypoactivity with major depressive disorder and fluoxetine (antidepressant) 80 mg by mouth daily for depression. Review of the antidepressant medication care plan, last revised on 4/2/26 showed interventions which included "Monitor/Document side effects and effectiveness Q shift." The following concern was identified: a. Review of the medical record showed there were no resident specific or medication specific target symptoms identified or monitored for the use of Adderall or fluoxetine. 4. Review of the annual MDS assessment dated 1/23/26 showed resident #4 had a BIMS score of 6 out of 15, which indicated the resident was severely	F0605		04/30/2026

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F0605 SS = E	Continued from page 6 cognitively impaired, and had diagnoses which included non-Alzheimer's dementia, anxiety disorder, and depression. Further review showed the resident received antipsychotic and antianxiety medications. Review of the physician orders showed the resident received brexpiprazole (antipsychotic) 0.5 mg every evening by mouth for agitation, lorazepam (antianxiety) 0.5 mg twice daily for agitation and anxiety, and 0.5 mg lorazepam by mouth as needed every 3 hours for agitation and anxiety. Review of the antipsychotic medication care plan, last revised on 12/16/25 showed interventions which included "Monitor behaviors of yelling out, cursing at staff, or sexually inappropriate comments. Document observed behavior and attempted interventions." The following concern was identified: a. Review of the medical record showed there were no medication specific target symptoms identified for the lorazepam. 5. Review of the MDS assessment dated 3/6/26 showed resident #5 had short-term and long-term memory impairment and had diagnoses which included non-Alzheimer's dementia, depression, and bipolar disorder. Further review showed the resident received antipsychotic and antidepressant medications. Review of the physician orders showed the resident received bupropion (antidepressant) 150 mg by mouth daily for major depressive disorder, fluoxetine (antidepressant) 20 mg daily by mouth for bipolar disorder, and olanzapine (antipsychotic) 5 mg daily at bedtime for bipolar disorder. Review of the antidepressant medication care plan, last revised 5/2/25 showed interventions which included “Monitor/document for side effects and effectiveness.” Review of the antipsychotic medication care plan, last revised 5/2/25, showed interventions which included “monitor for side effects and effectiveness.” The following concern was identified: a. Review of the medical record showed there were no resident specific or medication specific target symptoms identified for the Bupropion, fluoxetine, or olanzapine. 6. Interview with the DON, SSD, SDC, LPN #1, and the pharmacist on 4/9/26 at 9:01 AM confirmed the facility did not identify or monitor resident or medication specific target symptoms for psychotropic medications. 7. Review of the policy titled "Psychotropic	F0605		04/30/2026

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F0605 SS = E	Continued from page 7 Medications" provided by the facility on 4/9/26 showed "An unnecessary drug is any drug when used... (3) Without adequate monitoring..."	F0605		04/30/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F0584	Resident #31__ was identified as being affected. Resident #_31_ was interviewed and confirmed that: In December she was gifted a jacket, she wore the jacket but then wanted to gift to someone else as it had been gifted to her but didn't remember who it was gifted to. After review, was able to establish that it had been gifted and reviewed. All residents have the potential to be affected. Other residents were interviewed, as appropriate, to determine if they had any missing clothing item concerns that have not been resolved. The facility Social Worker will facilitate a missing clothing items log to use when a resident reports a missing clothing item. The log will be used to document efforts to locate the missing item and the resolution of the concern. All staff will be re-educated to report any concerns expressed by a resident of a missing clothing item so it can be addressed immediately. The facility Social Worker or designee will meet with the resident council monthly as allowed by the residents to monitor if concerns of missing clothing items are being addressed. Results of resident council interviews will be reported by the social worker to the QAPI Committee for the next 4 months. Additional training and/or audits will be instituted as appropriate to ensure ongoing compliance.	05/01/2026

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F0584 SS = D	Continued from page 8 This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, resident and staff interview, and grievance log review, the facility failed to ensure reasonable care for the protection of the resident's property from loss or theft for 1 of 4 sample residents (#31) reviewed for missing items. The findings were: 1. Interview with resident #31 on 04/06/26 at 4:51 PM revealed s/he stated concerns of a missing “short fuchsia colored jacket” s/he had only one day and “it’s been missing since then.” The resident stated s/he had mentioned it at the last care plan meeting and nothing had been done. 2. Review of a progress notes for resident #31 dated 1/23/26 and timed 2:28 PM showed “Per CNA resident refused [his/her] bath and stated I will not take a bath until my purple magnetic jacket is found. Staff has been looking for jacket and laundry has been notified.” 3. Interview with the SSD on 4/9/26 at 10:38 AM revealed she was not aware of a fuchsia jacket that was missing from resident #31. She stated when clothing went missing the process was to notify laundry. 4. Review of the grievance log for the past year revealed no grievances about clothing. 5. Interview with the administrator on 4/9/26 at 11:25 AM revealed “the facility will be completing a log process for missing clothing, and have that in the care plan meetings.” She revealed most clothing items were found quickly and she confirmed there was not a process for identifying missing clothing items. 6. Interview with the DON and LPN #1 on 4/9/26 at 11:53 AM revealed they recalled from the last care plan, the jacket in question was obtained by resident #31 from a volunteer, s/he wore it once, and then requested it to be donated. The were unsure what had happened with the jacket after that.	F0584		05/01/2026