POC accepted 9/27/11 Janeese Conkling RN

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

PRINTED: 08/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse DON - director of nursing MDS - Minimum Data Set CNA - certified nursing assistant MAR - medication administration record mg - milligram Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 169 SS=D	483.10(c)(2)-(8) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 169	The facility will ensure the individual financial records for resident funds will be available through quarterly statements and on request to the resident or his or her legal representative as evidenced by: 1. As in the case of residents #1, #6, #16, #20, #22, #25, #31, #32, #33, and #34, The Director of Finance shall prepare individual financial statements reflecting the account balance at the beginning of the quarter, deposits and withdraws, and the ending balance of the account. 2. The Director of Finance shall mail the statements to the resident or responsible party within 30 days after the end of the quarter.	9/22/11

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

Heather McL | Administrator | 9/26/11

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 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.

Changes made per phone call with Heather McLee, Admin. on 9/27/11 @ 11am

JC

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F 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, and resident and staff interviews, the facility failed to provide quarterly statements for 10 of 10 residents (#1, #8, #16, #20, #22 #25, #31, #32, #33, #34) whose personal funds were managed by the facility. The findings were: During an interview on 8/10/11 at 10:03 AM, resident #33 stated s/he had a personal funds account in the facility, but had never received a statement. According to a list provided by the facility on 8/10/11, the facility managed the	F 159	3. The Administrator will monitor and confirm statements have been sent to residents with personal fund accounts 4. The Administrator will report results at the quarterly QAA meeting with appropriate follow up.	

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F 156	Continued From page 2 personal funds for the following residents: #1, #6, #16, #20, #22 #26, #31, #32, #33, #34. On 8/10/11 at 2:45 PM, the resident funds manager stated she communicated with residents and/or family members about their funds, but did not provide written quarterly statements.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to assess and care plan 2 of 3 sample residents (#18, #23) with restraints to identify all restraining devices utilized by the residents and determine their medical necessity. The findings were: 1. Observation on 8/9/11 at 4:15 PM revealed resident #18 was able to get up and stand with limited to extensive assistance. However, at 4:30 PM that day the resident was observed to independently move his/her feet off the bed and attempt to stand. On 8/9/11 at 9:25 AM, the resident was observed sleeping in a recliner with his/her feet elevated. When the resident was awakened at 11:20 AM, the surveyor asked if s/he could lower the elevated foot rest so his/her feet were on the floor. After making several attempts, the resident repeatedly stated s/he was unable to lower the foot rest. Review of the medical record showed, that although the	F 221	The facility will ensure that all residents are free from any physical restraints imposed for the purpose of discipline or convenience as evidenced by: 1. All residents for which a restraint is needed will have an assessment done to show the medical symptoms for which the restraint is needed. 2. Resident #18 and resident #23 will have a full assessments done to support the medical need to use a recliner for their safety. 3. Care plan updates will be done on resident #18 and resident #23 to reflect the use of recliners for safety. 4. The DON will monitor assessments for restraints to assure they are accurate and appropriate. Assessments will be monitored monthly. 5. The DON will report at the quarterly QAA meeting with appropriate follow up.	9/6/11

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F 221	Continued From page 3 resident was assessed and care planned for use of a soft waist restraint while in a wheelchair, the recliner had not been identified as a restraint if the resident's feet were elevated. On 8/11/11 at 8:28 AM, DON #2 confirmed the recliner had not been identified, assessed, or care planned as a potential restraint. 2. Observation on 8/9/11 at 7:45 AM showed resident #23 was in a wheelchair with two alarms. The staff development coordinator stated one was a seat pressure alarm and one clipped on the resident as s/he would attempt to get up. According to the face-sheet, the resident was readmitted on 8/1/11 after surgery for a fractured hip. Observation on 8/9/11 at 11:10 AM showed the resident was transferred with a sit-to-stand lift and was able to bear some weight on both legs. Observation on 8/10/11 at 10 AM revealed the resident sleeping in an electric recliner with the foot rest elevated. At that time CNAs #3 and #6 stated the resident was not able to lower the footrest independently. The CNA also stated the resident was ambulating prior to the fractured hip. Although medical record review showed the resident was assessed and care planned for a soft waist restraint, evidence was lacking that the recliner had been identified and assessed or care planned as a potential restraint. On 8/11/11 at 8:28 AM, DON #2 confirmed the lack of assessment.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have	F 225		

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F 225	Continued From page 4 had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure reasonable efforts were made to investigate the criminal	F 225	The facility will ensure reasonable efforts are made to investigate the criminal history of newly hired employees as evidenced by: 1. As in the case of LPN #13, employees whose DFS central registry screens that indicate "You may consider having a complete criminal history background check" will be further investigated by the Human Resource Manager. 2. The Human Resource Manager will interview the employee and report the results to the Administrator. 3. The Administrator will determine if a NCBI criminal background check is warranted. 4. If a NCBI check is ordered, the employee will be temporarily suspended pending results. 5. If there is a finding of abuse, neglect, mistreatment of residents, misappropriation of resident funds or any other action by a court of law that would indicate unfitness to serve as a nurse, nurse aide, or other staff member, the employee will be terminated. 6. The Administrator will report any finding of unfitness to serve to the State nurse aide registry or the appropriate licensing authority. 7. The Administrator will report results at the quarterly QAA meeting with appropriate follow up.	9/22/11

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F 225	Continued From page 5 history for 1 of 5 newly hired employees (#13) whose personnel files were reviewed. The findings were: Review of the personnel file of LPN #13, hired on 6/23/11, revealed a Department of Family Services (DFS) central registry screen was completed on 6/22/11. The employee was not listed on the abuse registry. However, the DCI (Division of Criminal Investigation) pre-screen indicated a criminal history was present, and the wording, "You may consider having a complete criminal history background check," was checked on the form. Further review of the personnel file revealed no evidence that the facility attempted to uncover any more information regarding the individual's criminal history. During an interview on 8/10/11 at 5:05 PM, DON #1 stated the wording was "may consider," so the facility didn't think they had to do a criminal background check. The DON acknowledged that knowing the criminal history of an employee was important, but stated no further action was taken since the results of the DFS screen were received.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of personnel files, staff interview, and review of policy and procedures, the facility failed to develop an abuse prevention	F 226	The Facility will ensure the Resident Abuse and Prevention Policy includes steps the facility will take if the DFS background check indicates a criminal history or suggests further investigation as evidenced by: 1. If an employee's DFS central registry screens that indicate "You may consider having a complete criminal history background check" will be further investigated by the Human Resource Manager. 2. The Human Resource Manager will interview the employee and report the results to the Administrator. 3. The Administrator will determine if a NCBI criminal background check is warranted. 4. If a NCBI check is ordered, the employee will be temporarily suspended pending results.	9/22/11

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F 225	Continued From page 6 policy which included procedures for ensuring follow up to the Department of Family Services (DFS) screening results. The findings were: Review of the facility's "Resident Abuse Prevention" policy (revised 2/07) revealed "All new hires will have DFS background checks completed..." However, the policy did not address steps the facility would take if the DFS background screening indicated a criminal history. Refer to F225 regarding details of the facility's failure to attempt to uncover information about possible criminal prosecutions for one of one newly hired employee whose DFS background screening indicated a criminal history.	F 226	5. If on the initial DFS check or subsequent NCBI screen there is a finding of abuse, neglect, mistreatment of residents, misappropriation of resident funds or any other action by a court of law that would indicate unfitness to serve as a nurse, nurse aide, or other staff member, the employee will be terminated. 6. The Administrator will report any finding of unfitness to serve to the State nurse aide registry or the appropriate licensing authority. 7. The Administrator will report results at the quarterly QAA meeting with appropriate follow up.	
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on review of the medical record and staff interview, the facility failed to obtained admission orders for 1 of 8 sample residents (#23) whose records were reviewed for admission orders. The findings were: Review of the medical record showed resident #23 was readmitted to the facility on 8/1/11 after being hospitalized for a surgical procedure. Further record review showed a form dated 8/1/11 and entitled "Admission Orders" was initialed by a nurse, but the information was not	F 271	The facility will ensure that when a resident is admitted there will be a signed physician order in place so that immediate care can be done as evidenced by: 1. Admission orders will be obtained and signed by the physician or an appropriate substitute on the day of admission. 2. The nurse admitting a new resident will monitor admitting orders for a physician signature and obtain one if it is not present. 3. The DON will review charts of new admissions to assure the admitting orders are signed and appropriate. 4. Admit orders for resident #23 were signed by the physician on 08/10/2011.	9/6/11

JC
9/09/11

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F 271	Continued From page 7 signed by the physician. On 8/9/11 at 2:55 PM, DON #2 confirmed the orders were unsigned and acknowledged they were not acceptable.	F 271	5. The DON will report at the quarterly QAA meeting with appropriate follow up.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	The facility will ensure that all residents have initial and periodical assessments done. These assessments will be comprehensive, accurate, standardized and reproducible assessments. This will be done as evidenced by: 1. Initial comprehensive assessments have been completed on resident #23. 2. An initial comprehensive assessment will be done by an RN within 24 hours of admit. 3. Quarterly assessments will be done by an RN every quarter in conjunction with the MDS schedule. 4. A comprehensive assessment will be done on any resident who has a change of condition. 5. These assessments will include contributing factors and the impact on the resident's quality of life and ability to function.	9/22/11

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F 272	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, resident and staff interviews, and review of incident reports and fall committee notes, the facility failed to provide comprehensive assessments in various areas for 2 of 10 sample residents (#18, #23). In addition, post-fall assessments were not completed for either resident. The findings were: 1. According to the 12/29/10 admission MDS assessment, resident #23 required comprehensive assessments for bladder incontinence, falls, psychotropic medications, and restraints. Review of the information identified by the facility as the comprehensive assessments showed it just reiterated that found in the MDS. Causes and contributing factors were not identified, and the facility failed to consider the impact on the resident's quality of life and ability to function. Furthermore, review of the 6/1/11 quarterly assessment showed the resident was incontinent of bowel; this was confirmed by observation on 8/9/11 at 11:10 AM. However, a comprehensive assessment for bowel incontinence was not completed. Refer to F221 for details related to lack of a restraint assessment. Medical record review showed the resident was re-admitted to the facility after undergoing surgery for a fractured hip sustained in a fall at	F 272	6. As in the case of resident #18, a fall follow up assessment will be completed after any fall of a resident and the assessment will be reviewed by the fall committee. 7. The DON will monitor and review charts and report at the quarterly QAA meeting with appropriate follow up	

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F 272	Continued From page 9 the facility. While being transferred on 8/9/11 at 11:10 AM, the resident was overheard to say, "It hurts so bad." Detailed review of the medical record showed no evidence a pain assessment was completed upon the resident's readmission. Further review of the record, incident reports, and notes from the fall committee showed no evidence a post-fall assessment had been completed. On 8/11/11 at 9:28 AM the MDS coordinator confirmed a current pain assessment was lacking and that the restraint assessment did not address all restraining devices. 2. According to 8/6/11 significant change assessment, resident #18 sustained falls while in the facility. Review of the nursing documentation showed the resident fell on 5/6/11, 6/3/11, 7/1/11, 7/2/11, and 8/3/11 and that several of the falls occurred when s/he tried to use the toilet independently. Detailed review of the entire medical record, the incident reports, and the fall committee notes showed post-fall assessments were not completed. 3. Interview with the MDS coordinator and DON #1 on 8/10/11 at 5:36 PM and the coordinator of the fall committee, CNA #12, on 8/10/11 at 5:35 PM confirmed post-fall assessments were not completed. Refer to F323 for additional information related to falls for resident #18. Refer to F221 for information related to lack of an adequate assessment for all restraining devices for both residents.	F 272		
F 273 SS=E	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive	F 273		

JC 9/9/11

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F 273	Continued From page 10 assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the admission MDS assessment was completed within 14 days for 7 of 10 sample residents (#9, #18, #23, #28, #33, #34, #36). The findings were: 1. Medical record review showed the following admission MDS assessments were not completed within the regulatory timeframe: a. Resident #33 was admitted on 2/14/11, but the MDS assessment was not completed until 3/29/11. It was 30 days late. b. Resident #18 was admitted on 3/24/11; the assessment was not completed until 4/13/11, 21 days after the completion deadline. c. According to the admission MDS assessment, resident #36 was admitted on 6/6/11. However, the assessment was not complete until 7/6/11, 19 days past the deadline. d. Review of the admission MDS assessment showed resident #34 was admitted on 11/15/10, but the assessment was not complete until 12/7/10; it was 9 days late. e. Resident #9 was admitted on 6/2/11; the MDS assessment was completed on 6/22/11. It was seven days late. f. Resident #28 was re-admitted on 1/6/11;	F 273	The facility will ensure that all residents have a comprehensive assessment completed within 14 calendar days after admission. 1. As in the case of residents #9, #18, #23, #28, #33, #34, and #36, the MDS Coordinator will assure there ~~is a~~ timely ~~admit~~ assessment is scheduled and that all those who complete sections of the MDS be notified in writing of it. 2. The MDS Coordinator will keep a record tracking when assessments are completed. 3. The MDS Coordinator will report results to the quarterly QAA with appropriate follow up.	9/22/11 JC

JC 9/29/11

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F 273	Continued From page 11 the assessment was not completed until 1/25/11. Per regulation, it should have been completed by 1/20/11. g. Resident #23 was admitted on 12/15/11 and the admission MDS assessment was completed on 12/29/11, one day late. 2. During an interview on 8/10/11 at 8:55 AM, the MDS coordinator stated she recently took over this position, and had identified a problem with the timeliness of MDS assessments.	F 273		
F 276 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a comprehensive MDS assessment was completed not less than every 12 months for 1 of 1 sample resident (#3) who required an annual assessment. The findings were: Review of the medical record on 8/9/11 for resident #3 showed the last comprehensive assessment was dated 7/21/10. During an interview on 8/9/11 at 3:46 PM, the MDS coordinator stated an annual MDS assessment was due 7/22/11, but was not yet complete.	F 276	The facility will ensure that a comprehensive assessment be done every 12 months for every resident as evidenced by: 1. As in the case of resident #3, the MDS Coordinator will keep a calendar of all assessments due and notify all persons responsible for completing sections of the MDS in writing and complete assessments in a timely manner. 2. The MDS Coordinator will keep a tracking record to assure all assessments are completed when they are due to be. 3. The MDS Coordinator will report results of the tracking record at the QAA meeting quarterly meeting with appropriate follow up.	9/22/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	Continued From page 12 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff followed professional standards of practice related to medication administration. This failure was evidenced in the following manner: The findings were: 1. Failure to compare the label with the MARs: Observation of six licensed nurses (RNs #4 and #7 and LPNs #5, #8, #9, and #10) during fifty medication passes for ten residents (#2, #9, #11, #15, #16, #21, #22, #27, #28, and #30) from 8/8/11 through 8/10/11 showed none compared the medication labels with each resident's MAR. On 8/10/11 at 4:18 PM, DON #2 acknowledged that staff should compare each label with the appropriate MAR. Refer to F332 for details related to medication errors. Reference: Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 572, "Check medication label three times before administering the medication: When retrieving...from storage...When preparing...When returning...to storage." 2. Orders not followed as written: Review of physician's orders for resident #11 showed on 6/13/11 the physician ordered Prilosec ER 20 milligrams (mg) everyday "for one month, then stop." However, review of the MARs for July	F 281	F281--F The facility will ensure that medications are administered appropriately by the nursing staff as evidenced by: 1. Licensed nurses will compare the label to the MARs for medications administered to residents #2, #9, #11, #15, #16, #21, #22, #27, #28, and #30. 2. Licensed nurses will follow physician orders as written for resident #11 3. Licensed nurses will clarify orders for residents #23 #30, and #33. 4. Licensed nurses will document late administration of medication for resident #28. 5. There will be an in-service done for all nursing staff by our consulting pharmacist on 09/06/2011 to review the 'five rights' of medication administration. 6. There will be a nursing inservice on 09/06/2011 to review procedures of taking orders. 7. Periodic observation of medication pass will be done by DON or designee on at least a weekly basis.	9/6/11

JC 9/19/11

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F 281	Continued From page 13 and August 2011 revealed the Prilosec was never stopped; the resident continued to receive the medication each day. During an interview on 8/11/11 at 8:30 AM, DON #2 stated the Prilosec should have been discontinued in accordance with the physician's order. Reference: According to the Wyoming State Board of Nursing Rules and Regulations Chapter 3 Standard of Nursing Practice, nurses must practice according to the orders of a physician, dentist, or midlevel practitioner. 3. Failure to clarify orders: a. Review of a form entitled "Admission Orders" dated 8/1/11 for resident #23 showed a physician's signature was lacking; nor had a nurse written the information as verbal orders. On 8/9/11 at 2:55 PM, DON #2 acknowledged the orders were not acceptable without a physician's signature; she confirmed they had been followed for nine days without proper authorization. Reference: Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 565, "Seven parts of medication orders" include "Signature of individual ordering..." b. Review of the physician's orders and the August 2011 MAR for resident #33 showed an order for "Calcium + D 500 mg" daily. It was unclear whether the 500 mg was for Calcium or Vitamin D. When questioned on 8/10/11 at 3:26 PM, DON #2 confirmed the order should have been clarified. She stated she was unaware that Vitamin D was manufactured in multiple strengths. Reference: Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills,"	F 281	8. All new orders will be reviewed by the receiving nurse and at least one more nurse to assure accuracy in transcription. 9. When receiving orders the nurses will review them to make sure there is a proper dose and route for all medications ordered. If the order is not clear the nurse will contact the physician for clarification as needed. 10. If a medication is not available from pharmacy when it is due to be given, the nurse will initial and circle her initials to indicate the medication was not available. If it becomes available later, the nurse will sign to indicate it was given, but will document the reasons and the time given on the comments page in the MAR. 11. All documentation of observed medication passes will be reviewed by the DON and reported at the quarterly QAA meeting with appropriate follow up.	

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F 281	Continued From page 14 Seventh Edition, 2008; 566, "If a written order is illegible or questionable for any reason, the physician must be notified for clarification." c. Observation on 8/8/11 showed LPN #9 administered a heaping liquid measurement medication cup (over 30 ml or two tablespoons) of Citrucel to resident #30 at 5:23 PM. On 8/9/11 at 1:33 PM the LPN verified the amount she administered. She also confirmed a dose had not been ordered, and it's absence had not been clarified with the physician. Review of the orders showed it was first written on 5/27/11; review of the MARs showed the order had been administered without a correct dose since that date. Refer to F332 for details concerning medication errors. Reference: Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 566, "If a written order is illegible or questionable for any reason, the physician must be notified for clarification." 4. Lack of documentation: While preparing medications for resident #28 on 8/9/11 at 8:30 AM, LPN #9 stated the resident was out of oxybutynin, but she would call the pharmacy and administer it on arrival as it was only given daily. At 6:56 PM that evening, the LPN stated the medication had not been administered, but the night nurse (RN #7 who worked 6 PM to 6 AM) would give it on arrival. Review of the MAR on 8/10/11 showed RN #7 signed out for the medication in the scheduled space, indicating it was given at 8 AM on 8/9/11. There was no documentation on the MAR to show the medication was administered late or to indicate why the night nurse's initials were in the 8	F 281		

JC 9/9/11

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F 281	Continued From page 15 AM space. On 8/11/11 during the exit interview at 11:40 AM, DON #1 acknowledged documentation of the late administration time was needed. Reference; Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 569, "Documentation may be considered to be the sixth right: the nurse should document the...time administered..."	F 281		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE; RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a discharge summary, including a recapitulation of stay, was completed for 1 of 1 discharged residents (#36). The findings were: Review of the medical record showed resident #36 was discharged to home on 6/29/11. Further review showed no evidence of a discharge summary. During an interview on 8/10/11 at 2:25 PM, the medical records manager confirmed there was no discharge summary or recapitulation of stay. She stated the facility did not do a recapitulation of stay for discharged residents.	F 283	The facility will ensure that a discharge summary, including a recapitulation of stay, will be completed on all residents who discharge to home as evidenced by: 1. A discharge summary, including a recapitulation of stay, was completed for resident #36. 2. The medical records manager will review the chart of all discharged residents to assure a discharge summary was done on any resident who discharges to home. 3. The DON will keep a tracking record of all discharged residents to assure discharge summaries were done when appropriate. 4. The DON will report findings at the quarterly QAA meeting with appropriate follow up.	9/22/11

JC 9/29/11

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 1 of 5 sample residents (#23) with bowel incontinence was toileted as expected to prevent bowel incontinence. The findings were: Observation on 8/9/11 revealed resident #23 was not toileted from 7:45 AM until 11:10 AM, an elapsed time of 3 hours and 25 minutes. At 11:10 AM CNA #3 stated the resident was incontinent of bowel. According to the 8/1/11 quarterly MDS assessment, the resident was incontinent of bowel; the "Shift Sheet," listed the resident as "incontinent." A toileting regimen was not indicated, but on 8/9/11 at 4:35 PM the CNA manager, CNA #12, stated all residents were to be toileted every two hours unless they were completely independent with that task. She further stated the "Shift Sheet" was the care plan but that toileting every two hours was not written as all CNAs were aware of the regimen and were expected to adhere to it.	F 309	The facility will ensure that all resident will be toileted every 2-3 hours as per their plan of care as evidenced by: 1. A nursing in-service will be done on 09/06/2011 with all nursing staff to review the expectation of any incontinent resident to be toileted every 2-3 hours as per their plan of care. 2. Resident #23 will be toileted every 2-3 hours and on request. 3. The DON and SD will complete random observation of CNAs and document results. 4. The DON will report findings at the quarterly QAA meeting with appropriate follow up.	9/6/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

JC 9/8/11

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F 315	Continued From page 17 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and staff interview, the facility failed to provide care to promote continence for 1 of 4 sample residents (#3) who were incontinent of bladder. The findings were: Review of the 7/21/10 annual MDS assessment revealed resident #3 was frequently incontinent of bladder. Observation on 8/9/11 revealed the resident was not offered nor assisted to the toilet from 8 AM until 11:40 AM (3 hours 40 minutes). When CNA #15 assisted the resident to the bathroom at 11:40 AM, the resident was incontinent of bladder. At that time, the CNA stated the resident should be assisted to the bathroom about every two hours. Review of the care plan on 8/9/10 revealed a toileting schedule was not included. During an interview on 8/9/11 at 3:20 PM, the CNA manager stated the care plans were not updated, but staff were instructed to toilet residents every two hours.	F 315	The facility will ensure that all residents who are incontinent be toileted every 2-3 hours as per their plan of care as evidenced by: 1. A nursing in-service will be done on 09/06/2011 with all nursing staff. There will be a review of 2. expectation of nursing staff to toilet incontinent residents every 2-3 hours per their plan of care. 3. Resident #3 will be toileted every 2-3 hours as per their plan of care. 4. The DON and SD will complete random observation of CNAs and document results. 5. The DON will report findings at the quarterly QAA meeting with appropriate follow up.	9/6/11
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 18 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of incident reports and fall committee notes, and staff interview, the facility failed to identify potential causes of falls and implement appropriate actions to decrease the possibility of future falls for 1 of 6 sample residents (#18) with falls. The findings were: According to the 8/5/11 significant change MDS assessment, resident #18 had moderately impaired cognition and was occasionally incontinent of bowel and bladder. Review of the care plan showed the resident was to be toileted every two to three hours. Review of the "Shift Sheet" showed the resident's bowel and bladder status was described as "Continent." However, in an interview on 8/9/11 at 4:35 PM, the CNA manager, CNA #12, stated all residents were to be toileted every two hours unless they were completely independent with that task. She further stated the "Shift Sheet" was used as the care plan but that toileting every two hours was not written as all CNAs were aware of the regimen and were expected to adhere to it. Review of recent nursing documentation showed the resident had fallen on 5/6/11, 6/3/11, 7/1/11, 7/2/11, and 8/3/11; several of the falls occurred	F 323	The facility will ensure that all residents will have an environment that remains as free of accident hazards as possible, and that all residents will receive adequate supervision and assistance to prevent accidents as evidenced by: 1. Resident #18 will be toileted every 2-3 hours as stated in her plan of care. 2. A nursing in-service will be held 09/06/2011 to review the facility policy on toileting residents. 3. The DON and SD will complete random observation of CNAs and document results. 4. The DON will report findings at the quarterly QAA meeting with appropriate follow up. 5. The falls committee will address all falls and their cause, and review appropriate steps to take to prevent further falls.	9/6/11

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F 323	Continued From page 19 while the resident was attempting to toilet independently. Observation on 8/8/11 at 4:15 PM showed the resident required extensive assistance to get out of bed, into the wheelchair, and stand and pivot to use the toilet. Observation when the resident was returned to bed showed the resident was able to get his/her feet off the bed and attempted to stand independently. At that time CNA #11 stated the resident would attempt to get up independently and had previously sustained a fracture from a fall. On 8/9/11 observation showed the resident was not toileted from 7:38 AM until 11:20 AM (3.76 hours). At 11:20 AM CNAs #6 and #3 stated the resident was usually continent and would ask to use the bathroom. Review of the incident reports with DON #1 verified several of the resident's falls occurred while trying to toilet independently. While reviewing the fall committee notes on 8/10/11 at 5:35 PM, the committee chairman stated all falls were reviewed and discussed. However, there was no documentation indicating the facility recognized many of the resident's falls occurred while trying to toilet independently, and an individualized toileting regimen had not been implemented.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329	The facility will ensure that all residents' drug regimens are free from unnecessary drugs.. Residents who use antipsychotic drugs will receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	9/22/11

JC 9/29/11

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F 329	Continued From page 20 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimens for 2 of 10 sample residents (#23, #28) were free of unnecessary drugs. The findings were: Failure to prevent use of psychotropic medications for an extended period of time without attempting a dose reduction was identified as follows: a. According to the admission face sheet and the orders, resident #23 was admitted on 12/16/10. The physician started the antidepressant, Lexapro10 mg, on the same date, and review of the MARs showed it was administered as ordered. Review of the 12/29/10 admission and 9/1/11 quarterly MDS assessments showed the resident had minimal	F 329	1. For residents #23 and #28 the physician has documented the clinical rationale why a gradual dose reduction is contraindicated. 2. A chart review will be accomplished to identify residents affected by the deficient practice 3. Recommendations for gradual dosage reduction (GDR) are indicated on the monthly medication regimen review (MRR). The GDR Risk/Benefit form will then be reviewed by the Director of Nursing who will review charts to ensure that the physician has signed and annotated the form. If an appropriate risk vs. benefit statement has not been entered by the next monthly review, the consulting pharmacist will call the physician and note his response on the form with the appropriate notation of time and	

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F 329	Continued From page 21 indicators (01) of depression. Review of the pharmacist's monthly medication regimen reviews (MRR) showed she recommended a gradual dose reduction (GDR) on 5/26/11. Also on the form was an area for the physician to agree or disagree with the recommendation. If the physician disagreed based on the benefits versus the risks, s/he was to document the reason. Further review of the form showed the physician had written "Stable will consider" but failed to document the benefits versus the risks or provide a medical rationale showing why a reduction was clinically contraindicated. The physician did not sign the recommendation until 7/9/11. b. Review of physician orders showed Prozac 40 mg daily (an antidepressant) was first ordered on 1/6/11 for resident #26. Review of the MARs showed the medication had been administered from that date through August 9, 2011. Review of the MRRs showed the pharmacist recommended a GDR on 5/26/11. The physician checked the area indicating he disagreed with the recommendation. However, the section for documenting the clinical rationale was blank. The physician signed this MRR on 7/7/11, over a month after the pharmacist completed it. At 8:28 AM on 8/11/11, DON #2 confirmed a physician failed to document the benefits versus the risks for continuing each medication at the same dose or provide a clinical rationale showing why a GDR was contraindicated.	F 329	date. This procedure will ensure that all forms are properly and appropriately completed in the future. 4. A memorandum will be written to the clinic physicians from the facility medical director outlining the requirements for appropriate notation of clinical rationale for agreement or disagreement (i.e., a risk vs. benefit statement) with the recommendation. They will also be informed that if the forms are not correctly annotated, they will be contacted by the Director of Nursing and/or the consulting pharmacist. 5. The Director of Nursing will report findings at the quarterly QAA meeting with appropriate follow up.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

JC 9/29/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 332	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Out of 50 opportunities for errors, 9 errors were committed resulting in an error rate of 18%. The errors affected residents #11, #15, #28, and #30. The findings were: 1. Observation showed RN #4 administered Combivent for resident #11 to inhale twice on 8/8/11, once at 5:09 and once at 5:11 PM. During the second inhalation, the resident failed to form a seal around the inhaler by closing his/her lips prior to inhaling. Thus, the correct amount of medication was not inhaled by the resident. The RN observed the failure but provided no instructions to the resident as to how to inhale properly. Reconciliation with the physician's orders showed the resident should have received two full inhalations of the medication, a bronchodilator to make breathing easier. Interview with the RN immediately after the medication pass confirmed she saw that the resident did not close his/her lips around the inhaler. Review of reference material provided by the facility showed "Put the mouthpiece [of the inhaler] into your mouth and close your lips." 2. LPN #9 was observed to prepare and administer one heaped liquid measure medication cup (over two tablespoons) of Citrucel to resident #30 at 5:23 PM on 8/8/11. Reconciliation of the medication showed the physician had not ordered the dose to be administered. At 1:33 PM on 8/9/11, the LPN	F 332	The facility will ensure that medication error rate be <5% for all residents as evidenced by: 1. An in-service for all professional nursing staff will be held 08/06/2011 with our pharmacy consultant. J This will include the 'five rights' of medication administration. 2. Residents #11, #15, #28, and #30 will have their med pass monitored randomly by DON and SD. 3. Medication passes will be randomly monitored by DON and SD nurses. 4. The DON will report findings at the quarterly QAA meeting with appropriate follow up.	9/6/11

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	535017	A. BUILDING _____ B. WING _____	C 08/11/2011

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F 332	Continued From page 23 acknowledged she gave over two tablespoons of the medication. When asked why she chose to administer that dose, the LPN stated the bottle had no cap. Review of the MAR showed no instructions for the amount to be administered. On 8/10/11 at 7:05 PM LPN #8 administered one tablespoon of Citrucel to the resident. Even though this LPN administered the amount recommended by the manufacturer, the physician had not prescribed the dose. 3. On 8/8/11 at 6:33 PM RN #4 was observed to administer Fiberzon 1 capsule, Vitamin C 500 mg, and one tablet of Mapap 650 mg to resident #15; these medications were administered with four ounces of water. Reconciliation of the medications showed Fiberzon should have been administered with eight ounces of water, Vitamin C 500 mg was ordered instead of 500 mg, and two tablets of Mapap 650 mg were ordered instead of one. On 8/9/11 at 1:35 PM LPN #9 stated the family brought in the Vitamin C; she also stated she was unaware of the instructions on the MAR to administer 500 mg. Three medications errors occurred during this observation. Observation on 8/9/11 showed LPN #10 prepared and administered Fiberzon 1 capsule and Vitamin C 500 mg to the resident at 5:51 PM, again with four ounces of water. Reconciliation of the medications showed the orders remained as specified above. This LPN also stated the family brought in the Vitamin C. Two errors occurred with this medication pass, but a total of five errors were made in administration of medications for this resident. 4. Observation on 8/9/11 showed LPN #9	F 332		

JC 9/29/11

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F 332	Continued From page 24 administered two capsules of potassium chloride 10 milliequivalents to resident #26. Reconciliation of the medications showed the physician ordered only one capsule. At 1:06 PM that day the LPN verified that she gave two capsules and that the instructions on the MAR were for only one.	F 332		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	The facility will accurately post daily Nurse Staffing information as evidenced by: 1. There will be a nursing in-service on 09/06/2011 to cover how to accurately put information on the dry erase board in the hallway across from the nurses station. 2. The information will be posted at the beginning of each shift and updated as changes occur. The information will be transferred to paper at the end of each day and those sheets will be kept for 18 months. 3. Each staff member will only have time entered for one area or their hours will be divided if they work in more that one area for the day. 4. Any staff member who comes in for one-to-one care will be added to the board. 5. The DON will report findings at the quarterly QAA meeting with appropriate follow up.	9/6/11

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

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F 356	Continued From page 25	F 356		
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of hard copies of the posted information and the nursing schedule, the facility failed to ensure accurate staffing levels were posted for public review. The findings were: Observation on 8/9/11 at 11:40 AM showed staffing levels for the morning shift were posted on a large dry erase board. The information included 4 CNAs (each working 8 hours for a total of 32 hours that shift) and 1 restorative aide (RA) for 8 hours, as well as the remaining staff. Comparison of that information with the nursing schedule showed the RA was a CNA, but she was only working as the RA; therefore, the posted information was incorrect as there were only 3 CNAs available to provide a total of 24 hours of resident care. At 11:45 AM that day, DONs #1 and #2 confirmed the posted information was inaccurate. In addition, at 2:45 PM that afternoon, the DONs stated the night nurse would make a paper copy of information to be posted the next day. This copy was kept, but it did not include any changes made on the board throughout the day. Review of the copies showed no evidence changes had been made, and a staff member called in the morning of 8/9/11 to provide one-to-one care for a resident had not been added.			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

JC 9/8/11

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F 425	Continued From page 26 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure medications were available for administration as scheduled for 1 of 10 (#28) residents observed during medication passes. The findings were: While observing medications prepared for administration to resident #28 on 8/9/11 at 8:35 AM, LPN #9 stated oxybutynin was not available. The LPN stated she would call the pharmacy. According to the physician's orders, oxybutynin was to be administered daily, and it was scheduled on the MAR for routine administration at 8 AM. At 5:55 PM that evening, the LPN stated the medication had not yet been delivered.	F 426	The facility will ensure that all residents have medications to administer when they are ordered to be given as evidenced by: 1. Medications will be available for administration as scheduled for resident #28. 2. Professional nursing staff will have an in-service from our pharmacy consultant on 09/06/2011. 3 Nursing staff will be responsible to order medication if we will be out before monthly cycle fill medications arrive. 4 If a medication is not available to administer, the nurse will sign and circle the initials to indicate the medication was not given. There should be an entry made on the comments page of the MAR to explain why the medication was not given. 5 The DON will report findings at the quarterly QAA meeting with appropriate follow up	9/6/11
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=E	Continued From page 27 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	The facility will ensure the establishment and maintenance of an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection as evidenced by: 1. As in resident #28, the facility will ensure glucometers are cleaned in accordance with APIC guidelines. A. The Infection Control nurse will develop and implement policy and procedure in accordance with the APIC guidelines regarding the proper use and cleaning of glucometers. B. The Infection Control Nurse will conduct an in service with staff explaining the policies and procedures regarding the proper use and cleaning of glucometers C. The Infection Control Nurse will monitor results through periodic checks on staff and will report at the quarterly QAA meetings with appropriate follow up.	9/22/11

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F 441	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's instructions, policies and procedures, and nationally recognized standards, the facility failed to appropriately clean a glucometer after 1 of 1 observations of use (resident #28); failed to terminate precautions for one resident (#5) infected with MRSA: Methicillin-resistant Staphylococcus aureus (a drug-resistant bacterium); and failed to establish a mechanism to ensure laboratory results were sent to the facility, affecting non-sample resident #6. In addition, the facility failed to implement appropriate surveillance activities, particularly in relation to hand hygiene. The findings were: 1. With regard to glucometer cleaning: On 8/9/11 at 5:30 PM, LPN #9 was observed obtaining a finger stick blood sugar result for resident #28. The LPN placed the glucometer on the resident's bed and the case on the table. After obtaining the results, the LPN replaced the meter in the case and returned it to the medication cart without cleaning either item. At 5:35 PM the LPN confirmed she had not cleaned the glucometer, but she immediately did so with an alcohol pad. Review of the manufacturer's instructions showed "Clean the outside of the meter with...alcohol prep pad." On 8/10/11 at 4:40 PM DON #1 stated staff were to use a SaniCloth and not alcohol for cleaning glucometers. However, she stated staff had not yet been inserviced on the change. During an interview on 8/11/11 at 7:55 AM, the infection control practitioner (ICP) stated she had	F 441	2. As in resident #5 the facility will ensure policies and procedures are followed for the termination of MRSA precautions: A. The Infection Control Nurse and the facility medical director established policies and procedures regarding the guidelines for the termination of precautions for residents who have been infected with MRSA, specifically for MRSA in the urine. B. The Infection Control Nurse will conduct an in service with nursing staff on the MRSA policies and procedures. C. The Infection Control nurse will monitor compliance with policies and procedures and report results at the quarterly QAA meeting with appropriate follow up.	

JC 9/8/11

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F 441	Continued From page 29 given verbal instructions to some staff to use the SaniCloths. She further stated a new policy and procedure had been developed, but staff had not yet been inserviced on it. Reference: The CDC publication "Guideline for Disinfection and Sterilization in Healthcare Facilities", 2008, does not recommend the use of alcohol to disinfect equipment when blood borne pathogens, such as hepatitis viruses, are a concern. The APIC recommendations for disinfecting point-of-care devices are published in the American Journal of Infection Control, April 2010. The APIC guideline recommends glucometers be disinfected with a dilute bleach solution or an Environmental Protection Agency (EPA) -registered disinfectant effective against hepatitis and human immunodeficiency viruses. Alcohol is not an EPA-registered disinfectant for blood borne pathogens. Both CDC and APIC further recommend that if a point-of-care device, such as a glucometer, cannot be effectively disinfected, then it should not be used to test multiple patients. 2. With regard to terminating MRSA precautions: Review of nursing documentation dated 5/27/10 showed resident #5 displayed symptoms of a urinary tract infection (UTI), and a dipstick urinalysis (UA) showed elevated white cells. The physician was notified and ordered a culture and an antibiotic for seven days. According to culture and sensitivity results dated 5/30/11, the resident had MRSA in the urine that was sensitive to the ordered antibiotic. Repeat UAs on 6/1/11 and 6/27/11 showed the resident still had MRSA.	F 441	3. The facility will ensure laboratory results are provided the facility. A. The Infection Control Nurse informed the Medical Director of the Pinedale Clinic that test results performed on residents must be sent to the facility, including specifically, as in resident #5, urine results to ensure appropriate precautions or actions are taken as dictated. B. The Infection Control Nurse will conduct an in service with nursing staff to ensure all UA/CS tests performed at the Pinedale Medical Clinic are sent to the IC for review prior to being filed in residents' charts. C. The Infection Control Nurse will monitor outcomes and report at the quarterly QAA meetings with appropriate follow up.	

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F 441	Continued From page 30 Treatment with a different antibiotic was begun on 7/1/11 and completed on 7/11/11. No other laboratory tests had been conducted by 8/11/11 to determine if the resident was clear of MRSA. Interview with the ICP on 8/11/11 at 7:55 AM confirmed no other laboratory tests were run. The ICP stated the facility's policy to determine if a resident was free of MRSA was to have two negative cultures. Review of the policy, "Guidelines for the termination of precautions for residents who have been infected with Methicillin Resistant Staph Aureus (MRSA)" verified the ICP's statement. The policy instructed that the first culture be taken 72 hours or more after the antibiotic treatment was discontinued; the second was to be taken a week after the first. 3. With regard to laboratory results not sent to the facility; According to culture and sensitivity results dated 5/30, 6/1, and 6/27/11, resident #5 had MRSA in the urine. All of the laboratory tests were obtained in the physician's office and sent elsewhere for completion. Per interview with the ICP on 8/11/11 at 7:55 AM, the laboratory results were not sent to the facility. The ICP stated she would have had no knowledge of the infection if she had not personally requested the results. She further stated the facility did not ever get laboratory results from the clinic. She acknowledged that made it difficult to manage an effective infection control program. 4. With regard to surveillance activities; In interview on 8/11/11 at 7:55 AM, the ICP stated there was no formal process for facility-wide	F 441	4. The facility will establish a formal process for facility-wide surveillance of infection control practices A. The Infection Control Nurse will establish a surveillance program with policies and procedures updated in each department. B. The Infection Control Nurse will conduct in services with all departments to present overall and department-specific infection control surveillance policies and procedures C. A monitoring system will be developed with staff development to monitor the nursing staff in care that is being delivered in areas of hand hygiene, peri-care, catheter care, disinfecting of the bath tub, etc D. The Infection Control Nurse will report findings at the quarterly QAA meeting with appropriate follow up	

JC 9/29/11

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F 441	Continued From page 31 surveillance of infection control practices, particularly related to hand hygiene. She stated she observed nursing staff in the dining room and would provide immediate education if necessary. However, she did not monitor other departments, such as dietary, housekeeping, and maintenance, and she had no knowledge of any program for monitoring them.	F 441		
F 495 SS=D	483.75(e)(4) NURSE AIDE WORK < 4 MO - TRAINING/COMPETENCY A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to ensure an individual working as a nurse aide (NA) for less than 4 months in the facility had completed a NA training and competency evaluation program for 1 of 1 newly hired NAs whose personnel files were reviewed. The findings were: Review of the personnel file for NA #14 who started working in the facility on 5/21/11 revealed no evidence the individual had participated in a NA training and competency evaluation program.	F 495	The facility will ensure that all aids working with residents have documentation confirming they have completed competency training as evidenced by: 1. The facility has ensured that NA #14 has confirmation of State specific nurse aid licensure. 2. All future NA students will be required to provide proof of completion of a State Certified Nurse Aid course to the CNA manager prior to beginning work in the facility. 3. The CNA manager will monitor results and report at the quarterly QAA meeting with appropriate follow up.	9/6/11

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F 495	Continued From page 32 In addition, there lacked evidence the individual had a graduate NA license through the Wyoming Board of Nursing. During an interview on 8/10/11 at 4:30 PM, the CNA manager stated the individual did complete a NA class in May; however, the facility did not have any documentation to confirm that.	F 495		
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of personnel files, and staff interview, the facility failed to ensure nurse aides (NAs) or CNAs were deemed competent for tasks assigned to them for 7 of 7 NAs and 16 of 16 CNAs. The findings were: Review of the personnel file for NA #14 who started working on 5/21/11 revealed no documentation of competency for NA skills. During an interview on 8/10/11 at 4:30 PM the CNA manager stated the facility currently had seven NAs working in the facility. She stated the facility did not do their own competency checks because they should have learned the skills in the NA class. During an interview on 8/11/11 at 11:28 AM, DON #1 stated the facility did not do competency checks for the CNAs. According to the August	F 498	The facility will ensure that all working CNAs will demonstrate competency in skills and techniques necessary to care for residents' needs as evidenced by: 1. All current CNAs will be given a skills check list to demonstrate their competency and the techniques necessary to care for residents' needs. 2. All CNAs will complete an annual skills competency check list in conjunction with their annual evaluation. Each will have a minimum of 2 weeks prior to their annual evaluation in which to complete the checklist. All skills must be observed and checked off by a nurse. 3. All NAs will be required to complete a skills check list with the Staff Development nurse prior to working independently with residents. 4. The CNA manager will monitor and report results at the quarterly QAA meetings with appropriate follow up.	9/22/11

JC 9/28/11

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F 498	Continued From page 33 2011 schedule, the facility had 18 full time CNAs and 1 part time working CNA in the facility.	F 498		
F 513 SS=E	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to establish a mechanism to obtain radiographic reports and file them in the records for 2 of 2 sample residents (18, #23) with orders for radiographic films. The findings were: Medical record reviews showed X-rays were ordered for residents #18 and #23. X-rays were ordered on 5/7/11 and 5/29/11 for resident #18 and on 7/27/11 for resident #23. None of the reports were filed in either medical record. On 8/11/11 in an interview at 7:55 AM, the assistant DON stated that radiographic, office, and laboratory reports were not sent to the facility from the clinic for any of the residents.	F 513	The facility will ensure that all laboratory/x-ray orders are followed up to obtain and file X-ray finding and test results. 1. The facility filed signed and dated x-ray reports in the clinical records of residents #18 and #23. 2. A system for review of x-ray and laboratory orders shall be developed to ensure that results are obtained from the clinic. a. A form will be developed to track x-ray and laboratory tests. b. When an order is written for a laboratory test or X-ray, the date ordered and the date it was accomplished will be noted on the form.	9/22/11

JC 9/29/11

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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 09/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

(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 498	Continued From page 33 2011 schedule, the facility had 15 full time CNAs and 1 part time working CNA in the facility.	F 498		
F 513 SS=E	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to establish a mechanism to obtain radiographic reports and file them in the records for 2 of 2 sample residents (18, #23) with orders for radiographic films. The findings were: Medical record reviews showed X-rays were ordered for residents #18 and #23. X-rays were ordered on 5/7/11 and 6/29/11 for resident #18 and on 7/27/11 for resident #23. None of the reports were filed in either medical record. On 8/11/11 in an interview at 7:55 AM, the assistant DON stated that radiographic, office, and laboratory reports were not sent to the facility from the clinic for any of the residents.	F 513	c. When the results are received and placed in the chart, that is also noted on the form. d. A nurse will be assigned to review the form weekly to ensure the results have been received. If they have not, the clinic will be notified that the results need to be sent to the nursing facility 2. In addition, a memorandum will be written by the facility Medical Director requesting that all x-ray and laboratory test results will be forwarded to the Sublette Center. 3. The Director of Nursing will report findings at the quarterly QAA meeting with appropriate follow up.	