POC accepted 7/8/05 Janeale Corum

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

PRINTED: 06/23/2005
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
	535040	A. BUILDING _____ B. WING _____	R 06/09/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL MANOR	1106 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 164} SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure privacy during cares for one of six sample residents (#22) for whom cares were observed. The findings were: Observation on 6/8/05 at 2:30 PM revealed a certified nurse aide removed resident #22's top. A "Helping Hand" aide entered the resident's room without knocking, went into the resident's bathroom, and the resident, who was still bare-chested, was unnecessarily exposed.	{F 164}	The facility will ensure personal privacy will be maintained for each resident. This will be accomplished by: All staff will be inserviced concerning privacy issues. These issues are to address privacy to Resident #22 as well as the other residents in the facility. These privacy issues are to include knocking on the door to the resident room, prior to entering, and waiting for a response from before entering the room. Staff will also be instructed to state what department they are from, i.e. dietary, nursing, housekeeping, etc. Nursing staff, as well as Helping Hands, will be inserviced monthly as to these privacy issues. Documentation of these inservices will be maintained by Administration. This issue will also be addressed in Q.A.	7/30/05

RECEIVED
JUL 06 2005
WYOMING DEPT OF HEALTH
HEALTH FACILITIES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beverly Nielson	NHA	6/30/05

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. Changed per call to Judy Pettijohn, assistant administrator on 7/21/05 @ 1330. POC = 7/30/05. J Corum

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{F 318}	Continued From page 1	{F 318}	This facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This will be accomplished by:	7/30/05
{F 318} SS=E	483.25(e)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policies, and staff interviews, the facility failed to provide range of motion services for five of six sample residents with limited range of motion (ROM)(#10, #11, #22, #39, #43). The findings were:	{F 318}	1) Restorative aide will be re-educated as to the necessity of performing range of motion, documentation of same, timeliness, and organization skills to complete all restorative tasks. Restorative aide will be sent to another facility that has a good restorative program for this training. 2) The last hour of the shift of the Restorative aide will be designated for documentation purposes. 3) Range of motion exercises are to include residents #10, #11, #29, #39, and #43 as well as other residents found to be in need of range of motion. 4) Restorative aide will be allowed to seek assistance from CNA's on the floor, if necessary, if available, to help her complete her tasks. 5) If the CNA staff is short, Restorative Aide will be scheduled to work the floor until after the morning meal. 6) CNAs can assist restorative with ambulating residents under restorative care to the dining room for meals.	
	Interview with the restorative aide on 6/8/05 at 1:35 PM revealed the aide was being reassigned to routine nurse aide duties about three times per week and was not, therefore able to complete restorative tasks for residents per orders. Review of the restorative record book revealed residents #32 and #22 who had identified restorative needs had received no restorative services during the month of May 2005. Resident #33 was documented as receiving restorative exercises 9 days in May, although ordered to receive range of motion exercises 3 times per week. Resident #45's May restorative documentation showed the resident refused once, and had received restorative services on 5/5/05 and 5/10/05. There was no documentation for any resident the first 8 days in June. Review of the 3/2/05 quarterly minimum data set			

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{F 318}	Continued From page 2 (MDS) assessment revealed resident #43 had ROM limitations in the following areas: neck, both hands, both legs, and both feet. Review of a 11/19/04 hospital discharge summary showed the resident had flexion contractures. Review of the 11/19/04 admission nursing note showed the resident was stiff in the joints that were contracted. Review of the restorative nursing plan dated 9/7/04 revealed the resident was supposed to receive ROM to the upper extremities. Review of the January 2005 restorative flow sheet showed the resident received ROM services five times. Review of the February and March 2005 restorative flow sheets revealed they were blank; there were no documented ROM services provided. Review of the April 2005 flow sheet (up through 4/7/05) revealed it was also blank. During an interview on 4/7/05 at 11:05 AM, the administrator stated the previous restorative aide did not document services provided. She further stated the current restorative aide was being pulled off of restorative to "work the floor" (as a certified nurse aide). Review of the 3/25/05 quarterly MDS assessment showed resident #22 had ROM limitations in the following areas: both legs, both feet, and other limitations. Review of a 1/6/05 physical therapy clarification order showed the resident was discharged to restorative. Review of the 1/14/05 restorative referral showed the resident was supposed to receive lower extremity exercises and ambulation one to two times per week. Review of a 3/23/05 physician progress note showed the resident had pain in the knees, and the facility was supposed to do a re-trial of restorative care. Review of the care plan dated 1/6/05 showed the resident received the restorative program as tolerated. However, review	{F 318}	F 318 (Continued from page 2) These instances will be reported to Restorative Aide for documentation. 7) This program will be evaluated in 90 days. If the program has not proceeded satisfactorily within 90 days, steps will be taken to remedy the program to satisfaction. Another staff member may be hired to assist Restorative Aide. 8) The activity director will continue the weekly exercise program for the residents. 9) Inservices will be held for all staff as to the necessity of ensuring range of motion for residents. Nursing staff can assist with range of motion exercises at periodic times during the day. 10) Care plans will be updated for residents #10, #11, #22, #39, and #43. Care plans will be updated to reflect information on the MDS. MDS Coordinator will inform Restorative Aide of any changes in the MDS which reflect the restorative needs of any residents, including residents #10, #11, #22, #39, and #43. 11) PCPC team will review residents' needs and the communication of these needs to restorative care at their quarterly PCPC meetings. This issue will also be addressed in QA.	7/7/05

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{F 318}	Continued From page 3 of the February, March, and April (through 4/7/05) 2005 restorative flow sheets showed they were blank. During an interview on 4/7/05 at 11:05 AM, the administrator stated the previous restorative aide did not document services provided. She further stated the current restorative aide was being pulled off of restorative to "work the floor" (as a certified nurse aide). Review of the 3/4/05 quarterly MDS assessment showed resident #10 had ROM limitations in both legs and feet. Review of the 9/9/04 RAP module for activities of daily living showed the resident had one or more limbs that was severely impaired. The 3/1/05 nursing summary indicated the resident had a contractures to the leg and foot. Review of the medical record revealed no evidence the resident received ROM services. The care plan dated 3/17/05 did not address the resident's ROM limitations. Review of the restorative documentation book provided by the facility revealed the resident was not receiving restorative services. During an interview on 4/7/05 at 11:05 AM, the administrator stated if there was no documentation in the restorative book, then the resident was not receiving restorative services. During an interview on 4/7/05 at 11:05 AM, the administrator stated the previous restorative aide did not document services provided. She further stated the current restorative aide was being pulled off of restorative to "work the floor" (as a certified nurse aide). Review of restorative flow sheets in the restorative book showed the restorative aide documented he/she was pulled to work as a certified nurse aide on 2/28/05, 3/2/05, 3/3/05, 3/4/05, 3/7/05, 3/8/05, 3/9/05, 3/21/05, 3/23/05, and 3/24/05.	{F 318}		

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{F 318}	Continued From page 4 Review of the facility's policy for ROM exercises (NP2-1502, 1/96) showed ROM exercises improve or maintain joint mobility and help to prevent contractures. The policy stated the joints exercised and the number of repetitions should be documented on the restorative nursing flow sheets.	{F 318}		
{F 323} SS=D	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to store nursing supplies out of reach of residents,and to ensure a dumbwaiter was not accessible to residents. The findings were: 1. Observation on 4/7/05 at 4:35 PM revealed a clean utility room which had an unlocked door. This was again observed on 6/9/05 at 11:00 AM. In one of the unlocked cabinets, there were medical supplies including iodine swabsticks and two, 16-oz bottles of mineral oil. On the counter top there was a gallon container labeled "10:1 Bleach Water," which had no lid and was approximately 1/8th full. The contents smelled like bleach. In addition, the room contained a dumbwaiter (elevator) to transport clean linen from the basement to the main floor. The door to the dumbwaiter was not locked. The opening to the dumbwaiter measured 23 inches by 33 inches. Upon looking inside, the elevator was in	{F 323}	This facility will ensure that each resident's environment remains as free of accident hazards as is possible. This will be accomplished by: 1) The locking door knob on the clean utility room, which contains medical supplies, was removed and replaced with a key pad/combination locking door handle. The door cannot be opened without entering the combination. This not only keeps the residents safe from the medical supplies but also keeps the residents from possibly entering the dumbwaiter. 2) The locking door knob on the basement door was also replaced with a key pad/combination locking door handle. This prevents residents from opening the basement door, thus preventing an accidental fall. 3) Cabinet doors at the nursing station are equipped with locks. Staff has been instructed to keep those cabinets locked when not in use. This is being monitored as often as possible by other staff to ensure compliance.	6/12/05 6/12/05 7/30/05

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{F 323}	Continued From page 5 the down position (at the basement), therefore there was a drop off down to the basement. This problem was not corrected as of 6/8/05 at 2:30 PM. 2. Observation on all days of the survey showed the cabinets at the nurses' station were not locked and contained such items as syringes, needles, and alcohol and Betadine wipes. In addition, insulin was kept in the refrigerator, and the 1/2 door at the nurses' station was not always locked so the area behind the door was accessible to residents. Unlocked nursing supply cabinets were again observed on 6/8/05 at 1:45 PM and 3:20 PM. This portion removed as a result of the Informal Dispute Resolution held July 25, 2005 per Jean McLean, RD, Acting Manager, Office of Healthcare Licensing and Surveys. Deborah for JMcLean 7/26/05	{F 323}	F323 (Continued from page 5) 4) The swinging entry door to the nurses station is equipped with a lock. Staff has been instructed to keep the swinging door locked when not in use. This is being monitored as often as possible by other staff to ensure compliance. This issue will be addressed in QA.	7/30/05

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	This portion removed as a result of the Informal Dispute Resolution held July 25, 2005 per Jean McLean, RD, Acting Manager, Office of Healthcare Licensing and Surveys. J Schmitt for J McLean 7/28/05			

7/8/07

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Stricken
for J. McLean
7/28/05

Department of Health and Human Services
Centers for Medicare & Medicaid Service

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535040	A. Building B. Wing	6/9/2005

Name of Facility	Street Address, City, State, Zip Code
MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 05/23/2005	ID Prefix F0225 Reg. # 483.13(c)(1)(ii) LSC	Correction Completed 05/12/2005	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 05/05/2005
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 05/23/2005	ID Prefix F0271 Reg. # 483.20(a) LSC	Correction Completed 05/23/2005	ID Prefix F0274 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 05/23/2005
ID Prefix F0278 Reg. # 483.20(g) - (h) LSC	Correction Completed 05/23/2005	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 04/25/2005	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 05/10/2005
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 05/05/2005	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 05/23/2005	ID Prefix F0316 Reg. # 483.25(d)(2) LSC	Correction Completed 05/21/2005
ID Prefix F0324 Reg. # 483.25(h)(2) LSC	Correction Completed 05/23/2005	ID Prefix F0327 Reg. # 483.25(i) LSC	Correction Completed 04/28/2005	ID Prefix F0329 Reg. # 483.25(l)(1) LSC	Correction Completed 05/23/2005

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date: 6-17-05
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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ID Prefix F0406 Reg. # 483.45(a)(1)&(2) LSC	Correction Completed 04/28/2005	ID Prefix F0454 Reg. # 483.70 LSC	Correction Completed 05/23/2005	ID Prefix F0467 Reg. # 483.70(h)(2) LSC	Correction Completed 05/23/2005
ID Prefix F0495 Reg. # 483.75(e)(4) LSC	Correction Completed 04/11/2005	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	Correction Completed 05/23/2005		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
			Alan McRae	6-17-05
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		
4/7/2005		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO