Reviewed and approved with changes on page 5 of discussion

PRINTED: 03/22/2007
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
	53A049	A. BUILDING _____ B. WING _____	C 03/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

4/9/07 @ 10:15 Rec'd by Becca RN

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F 155 SS=B	483.10(b)(4) NOTICE OF RIGHTS AND SERVICES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of medical records, the facility failed to ensure 3 (#2, #3, #64) of 15 sample residents had complete documentation of their advance medical directives. The findings were: 1. Review of the medical record for resident #2 revealed the 11/30/99 advance directives form was not signed by a witness. 2. Review of the medical record for resident #3 revealed the 7/16/04 advance directives form was not signed by a witness. 3. Review of the medical record for resident #64 revealed the 12/26/06 advance directives form was not signed by a witness. 4. During an interview with the social services director on 3/7/07 at 8:50 AM, it was revealed that residents' advance directive decisions were initially reviewed in the admission process. The social services director further stated the required signatures by the resident (or legal surrogate), the resident's physician, and a witness from either the facility or family were obtained at that time. She stated that, once completed at admission, the document was considered current unless the	F 155	The nursing facility will ensure the resident has the right to formulate an advanced directive. This will be done by the following: Residents # 2,3,64 advance directives will be reviewed, resigned, and witnessed. A. The Social Services Coordinator will examine all resident charts for witness signatures and obtain missing signatures. B. The Social Services Coordinator will educate nursing staff on advanced directives and need for witness signature. C. The Social Services Coordinator will monitor all new advanced directives for signatures on a monthly basis and report to QA quarterly.	4/21/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 4/2/2007

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.

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Licensing and Surveys

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F 155	Continued From page 1 resident (or resident's surrogate) requested changes. The social services director acknowledged a signature of a witness was required by facility policy, and these documents should have all been witnessed and signed.	F 155		
F 244 SS=D	483.15(c)(6) PARTICIPATION IN RESIDENT & FAMILY GROUPS When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, confidential resident interview, and review of resident council meeting minutes, the facility failed to ensure staff followed through with council concerns during seven of nine months reviewed. The findings were: Review of the resident council meeting minutes from 7/06, 8/06, 9,/06, 10/ 06, 11/06, 12/06, and 2/07 revealed residents were concerned about not having enough staff to care for them. Review of the 7/25/06 minutes revealed "... stated that they are really short of nurses and the ones they do have are getting tired." Review of the 8/29/06 minutes revealed the way some baths were given by new CNAs made one "want to go dirty." The minutes also documented that when baths were given residents felt "helpfless." Review of the 9/26/07 minutes revealed residents felt the facility needed "more nurses, and that they all need to be better trained in giving baths and they [residents] don't like to be left in the bath alone." Review of	F 244	The facility will encourage and facilitate resident participation in resident and family groups. The facility will listen to the views and act upon grievances and recommendations from residents and families, concerning proposed policy and operational decisions, affecting resident care and the life in the facility. This will be accomplished by the following: (A) The facility will require the appropriate discipline(s) to follow through with all council concerns and address each concern, either in person or in writing to be presented at the next scheduled council meeting. On 3/26/07, the Resident Care Director addressed the nurse staffing with the council. The Life Enrichment Services Manager will attend the next resident council meeting to address the staffing concerns. (B) Activity area employees will take responsibility for documenting all of the resident or family concerns, and providing the appropriate disciplines with the information, so that they can review and provide required feedback at the next scheduled resident council meeting. (C) A PI process will monitor the concerns, actions, and follow-up of issues	

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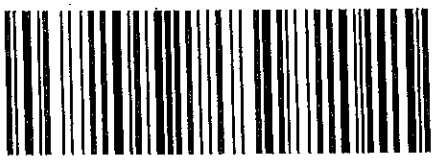

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F 244	Continued From page 2 the 10/24/06 minutes revealed a resident ....wished there were more nurses. Documentation in the same minutes revealed a resident felt staff were "not trained enough before they start." Review of the 12/26/06 minutes revealed residents were concerned that "it's taking way to long for the CNA's to answer lights." Review of the 2/27/07 minutes revealed staff were "overworked and too tired." The minutes also documented a resident's comment that "there is a shortage of help and it shows." Confidential interview with residents on 3/5/07 at 3 PM revealed residents have not yet received any feedback or a resolution to their concern about inadequate staffing. Interview with the director of activities on 3/7/07 at 8:55 AM revealed the activity staff moderated the resident council meetings at the resident's request. She stated the minutes were placed in department heads' mailboxes and if any of the department heads wished to provide feedback to the residents they could do so on their own. She confirmed there was no record of any follow-up regarding resident's issues.	F 244	raised at each monthly resident council meeting. The data will be collected monthly and reported to the QI team quarterly.	4/21/07
F 323 SS=E	483.25(h)(1) ACCIDENTS 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, staff interview, and review of MSDS (Material Safety Data Sheet) documents, the facility failed to ensure there was a safe environment for residents in 3 of 3 shower/bathing rooms. The findings were:	F 323	All noted hazardous items were removed at the time of the survey. added via telephone permission of Laurie Poston V.P. of Nsg on 4/1/07 @ 10:15 AM. LP The facility will ensure that the resident environment remains as free of accident hazards as is possible. This will be achieved by the following: (A) Resident bathing/shower rooms will be monitored for all potentially hazardous chemicals/products, and employees will keep these items stocked on shelving within the cabinets in each bathing room. (B) Touch pad keyless entry system will be installed on the doors of each bathing room, to ensure that all potentially	

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F 323	Continued From page 3 1. Observation of the 300 Hall bathing/shower room on 3/5/07 at 10:30 AM revealed it was not locked; the following items were accessible to residents in an unlocked cabinet: a. Located on the bottom shelf were two open 1/2 gallon containers of Apollo Turbo Clean each with a warning label: "Not for household use. Keep out of reach of children. Wear gloves to protect sensitive skin. Before disposal rinse container with fresh water. For external use only. If ingested call a physician, drink plenty of water and induce vomiting if necessary. Avoid eye contact." Review of the 12/12/01 MSDS revealed the cleaning agent could cause eye irritation, dermatitis, nausea and vomiting, or the mist could cause chest discomfort and coughing. b. On the top shelf was one aerosol can of "Arrid X" deodorant with the warning "Keep out of reach of children. If swallowed get medical help or contact a poison control center right away." 2. Observation of the 200 Hall bathing/shower room on 3/6/07 at 9 AM revealed it was unlocked and the following items were accessible to residents in an unlocked cabinet: a. One can of aerosol spray "Arrid X" deodorant on the top shelf with a warning label as noted above. b. Two straight edge razors were in a container on the second from the top shelf. c. Three 1 gallon containers of Classic Whirlpool Disinfectant; one container was open. Review of the 10/20/04 MSDS sheet revealed the agent could cause eye irritation and skin irritation. It further instructed the disinfectant was harmful if swallowed or if the spray mist was inhaled. 3. Observation of the 400 Hall bathing/shower room on 3/6/07 at 9:30 AM revealed it was not	F 323	hazardous materials are kept locked away from the direct reach of residents. (C) Safe storage of potentially hazardous materials will be monitored by the Life Enrichment Services Manager using a PI process. PI process will be collected monthly and reported quarterly.	4/21/07

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F 323	Continued From page 4 locked and the following items were stored in an unlocked cabinet that was accessible to residents: a. Five aerosol cans of "Arrid X" deodorant. b. Three open 1 gallon containers of Classic Whirlpool Disinfectant. c. One 22 ounce container of Shout stain remover. Review of the 5/12/05 MSDS sheet revealed it could cause moderate eye irritation and mild skin irritation d. Two 1/2 gallon containers of Apollo Turbo Clean Disinfectant. e. One spray can of Phenolcide Hospital Disinfectant. 4. Interview with a certified nurse aide (CNA #7) on 3/6/07 at 9:10 AM revealed the bathing/shower room doors could be locked, but rarely were. Interview with the resident care director on 3/6/07 at 5:30 PM confirmed the doors to the bathing/shower rooms and especially to the cabinets in those rooms should be locked.	F 323		
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353	The facility will ensure that there is sufficient nursing staff to provide for, attain, and maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility will provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. This will be achieved through the following actions:	

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F 353	Continued From page 5 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on confidential resident interview, staff interview, and review of bathing records, the facility failed to ensure there was adequate staff to provide care and services for 6 (#25, #35, #39, #60, #64, #68) of 15 sample residents and for two (#19, #13) non-sample residents. The findings were: Review of the bath schedules revealed all residents were scheduled for baths at least twice weekly. Interview with the resident care director on 3/7/07 at 10:20 AM confirmed bathing was scheduled twice weekly for residents. However, review of the bath/shower flow sheets for 2/07 revealed the following concerns: a. Review of the bathing schedule for resident #13 revealed s/he was scheduled for a shower on Wednesdays and Saturdays. Review of the flow sheet revealed the resident received only 4 showers during the month with one period of time between showers being nine days. b. Review of the bathing schedule for resident #19 revealed s/he was scheduled for a shower on Mondays and Thursdays. Review of the flow sheet revealed the resident received only 5 showers during the month instead of the scheduled 8 with one period of 10 days between showers.	F 353	(A) Resident bath/shower schedules are based upon resident preferences, needs, and the plans of care for each resident. All residents will be bathed according to their plan of care. (B) Baths/showers given to assigned residents will be documented on the appropriate resident record. (C) The caregiver will report to the charge nurse what baths/showers were given on the assigned shift. (D) If a resident is unable to take a bath/shower at his/her scheduled time, a make-up time will be scheduled. Care staff will be held responsible for bathing and documentation. (E) Charge nurses will monitor that bathing and documentation are completed. (F) In the event that all bathing rooms at Goshen Care Center are out of order, bed baths or Community Hospital bathing facilities will be utilized. (G) Resident's #13, 19, 25, 35, 39, 60, 64 and 68 did receive baths/showers on March 7th & March 8th and are now back on schedule. (H) The Life Enrichment Services Manager will monitor to ensure bathing schedules are being followed, or that alternative arrangements have been made to meet resident hygiene needs using a PI	

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F 353	Continued From page 6 c. Review of the bathing schedule for resident #25 revealed s/he was scheduled for bathing on Wednesdays and Saturdays. Review of the flow sheet revealed the resident received only 4 showers during the month instead of the scheduled 8 with one period between showers being 10 days. d. Review of the bathing schedule for resident #35 revealed s/he was scheduled for a shower on Tuesdays and Fridays. Review of the flow sheet revealed the resident received only 6 of the 8 scheduled showers during the month, e. Review of the bathing schedule for resident #39 revealed s/he was scheduled for a shower on Mondays and Thursdays. Review of the flow sheets revealed the resident received only 5 of the scheduled 8 showers during the month with one period being 13 days between showers. f. Review of the bathing schedule for resident #60 revealed s/he was scheduled for a shower on Tuesdays and Fridays. Review of the flow sheet revealed the resident received only 5 of the scheduled 8 showers during the month. g. Review of the bathing schedule for resident #64 revealed s/he was scheduled for a shower on Mondays and Thursdays. Review of the flow sheet revealed the resident received 4 of the 8 scheduled baths with one nine day period between showers. h. Review of the bathing schedule for resident #68 revealed s/he was scheduled for a shower on Wednesdays and Saturday/Sunday. Review of the flow sheet revealed the resident received only 6 of the 8 scheduled showers with one period of 8 days between showers. Interview with certified nurse aide #6 on 3/4/07 at 3:45 PM revealed staff had been short for a while and sometimes some things like baths /showers	F 353	process. The data will be gathered monthly and reported on a quarterly basis.	4/21/07

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F 353	Continued From page 7 did not get done. Confidential interview with residents on 3/5/07 at 3 PM revealed residents were concerned about not having enough staff and stated they do not always get their baths/showers as scheduled.	F 353		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure safe and sanitary storage conditions for food in five of five temperature-controlled storage areas in the main kitchen and one of two refrigerators used to hold resident food on the units. In addition, the facility failed to remove expired nutritional drink supplements from three of three holding areas for resident snacks and foods. The findings were: 1. Five temperature-controlled storage units were observed during the initial tour of the kitchen on 3/4/07 at 4:05 PM. These refrigerator and freezer units contained potentially hazardous foods including ground meat, poultry, eggs, dairy products, and produce. A clipboard holding temperature charting log sheets was observed hanging from a door in the dry storage area. These log sheets contained spaces where the temperatures of each refrigerator and freezer were recorded for each calendar day of the month. There were no temperature recordings	F 371	The facility will ensure that the food is stored, prepared, distributed and served under sanitary conditions. A). The outdated supplements were discarded at the time that they were found and revealed to the dietary manager on 3/4/07. B). A dietary meeting was held on 3/20/07 to inform the dietary staff that they will now be dating all supplemental products with the outdated date on them instead of the thaw date. All dietary staff will be responsible for checking at least weekly for outdated products and discarding them when they are found. The policy has been up-dated to reflect the expiration date and employees will initial and date to reflect their understanding of these changes made to the policy. C). The walk -in refrigerator has a new thermometer and will be monitored daily by the early cook. The early cook will log-in the temperatures on the charting log sheets. D). The dietary manager will be monitoring the log sheets on a weekly	

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F 371	Continued From page 8 documented for the current month (March 2007), six blank days (no temperature recordings) for February 2007, and 10 blank days for December 2006; the log sheet for January 2007 was missing from the clipboard. Interview with cook #1 on 3/4/07 at 4:35 PM revealed temperatures were to be recorded on the log sheets and the blank daily entries were because the kitchen staff forgot to monitor temperatures or forgot to write the temperatures on the log sheets. 2. A household-type refrigerator-freezer combination was observed in a common-use area on the 300 hallway at 5:50 PM on 3/4/07. The appliance was found to contain perishable snacks, sandwiches, and nutritional supplement drinks for residents. Temperature recording log sheets were found in an overhead cabinet. Review of the temperature recording log sheets on 3/4/07 at 6:15 PM revealed numerous days that lacked data to document safe storage temperatures for resident food and drink. Three days in February 2007 lacked temperature recordings, four days in January 2007 were blank, and December 2006 had six days in which no temperatures had been recorded; there was no log sheet in the bundle for the current month (March 2007). The resident care director stated in an interview on 3/5/07 at 10:55 AM the night maintenance staff were responsible for monitoring and recording temperatures for the refrigerator system. She confirmed the absence of temperature readings and stated "...it probably doesn't always get done when he [maintenance personnel] is gone..." 3. Inspection of a walk-in refrigerator on 3/4/07 at 4:20 PM showed the external thermometer registered 64 degrees Farenheit (F). No internal	F 371	basis and holding the staff responsible for daily temperatures. The dietary manager will also obtain temperature data on a monthly basis which will be reported quarterly to the Process Improvement Steering Committee. E). The dietary staff will be responsible for checking the nourishment center refrigerator on the 300 hall at least weekly for any outdated items and discarding. F). The environmental service manager will in-service temperature log issues and monitoring with the staff. G). The environmental service manager will monitor the log sheets on the 300 common area refrigerator and will hold the environmental staff responsible for logging daily temperatures. The environmental service manager will monitor temperature logs monthly and report to the Process Improvement Steering Committee on a quarterly basis.	4/21/07

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F 371	Continued From page 9 thermometer was found to compare against the external reading. Interview with cook #1 on 3/4/07 at 4:40 PM revealed the external thermometer had been broken "...for some time..." and further indicated"...there should be a thermometer inside, on the shelf..." A five minute search inside the walk-in refrigerator discovered a dial-type thermometer on the floor beneath a lower shelf. The thermometer was dirty with a sticky red liquid residue and had an area around the glass face, about 3/4 inches long, covered with a gray, moldy material; the thermometer registered a temperature reading of 52 degrees F when found on the floor. 4. Interview with the dietary manager on 3/5/07 at 10:20 AM revealed her expectation that staff monitor and record in writing the temperatures of cold storage equipment once each day. She acknowledged those days on the log sheets without temperature data reflected an oversight on the part of the kitchen staff. She further confirmed the external thermometer on the walk-in refrigerator was nonfunctional. The dietary manager replaced the internal thermometer in the walk-in refrigerator and a reading of 40 degrees F was observed on 3/5/07 at 10:35 AM. 5. Observations on the initial tour of the main kitchen area and resident units on 3/4/07 at 4:20 PM revealed there were three refrigerators used by staff to hold nutritional supplement drinks for residents. One refrigerator was in the dry storage room of the main kitchen, one was in the food serving kitchen adjacent to the main resident dining room ("servery"), and a third refrigerator was located in a common use area on the 300 hallway. Additionally, a stock of nutritional supplement drinks (shake products and	F 371	Left Blank Intentionally	

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F 371	Continued From page 10 fruit-flavored drinks) was observed in a freezer in the dry storage area. Each of the refrigerated nutritional supplement drinks was labeled with a hand-written date and each carton also contained a preprinted label from the manufacture establishing the product expiration date to be 14 days after thawing when kept in refrigerated storage. Interview with cook #1 revealed the hand-written annotation was the date the drink carton was removed from the freezer and thawed for use. The kitchen refrigerator contained two expired supplemental drinks, labeled "2-5" and "2-15", 27 days and 17 days post-thaw, respectively. The servery refrigerator contained one drink product labeled "2-12" indicating a 20 day post-thaw period. The 300 hallway refrigerator contained a supplemental drink labeled "2-12" indicating 20 days had elapsed since the product was thawed for use. Interview with the dietary manager on 3/5/07 at 10:15 AM confirmed the policy of dating each drink carton with the date of thaw and, further, agreed the supplemental drinks expired after 14 days in refrigerated storage. She also acknowledged nutritional supplement drinks labeled prior to 2/18/07 were expired and should be discarded.	F 371		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	The nursing facility will store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. This will be done by the following: 1) All medication room refrigerator thermometers were replaced to ensure accuracy of temperatures. All refrigerator temperatures are currently within the	

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	53A049	A. BUILDING _____ B. WING _____	C 03/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 431	Continued From page 11 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure temperatures were taken in 3 of 3 medication refrigerators. The findings were: Observation of the thermometer in the medication refrigerator on the 300 Hall on 3/7/07 at 9:15 AM revealed it registered as 48 degrees Fahrenheit (F). Interview with the resident care director on 3/7/07 at 9:15 AM confirmed the temperature reading was 48 degree. She stated temperatures should be taken every shift and documented on the log. Observation again at 1:45 PM on that same day revealed the temperature reading was	F 431	recommended parameters. 2) Charge nurses will record medication room refrigerator temperatures on a daily basis. The record will be turned into the LTC Assessment Coordinator as the form is completed. Failure to take and record the temperature will result in consultation with the Resident Care Director. 3) Staff will be in-serviced on the medication refrigerator temperature parameters and the action to be taken when those parameters are not met. Any necessary interventions will be implemented immediately by the Resident Care Director. 4) The LTC Assessment Coordinator will monitor the medication refrigerator records on a monthly basis. She will report to the PI Steering Committee on a quarterly basis.	4/21/07

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F 431	Continued From page 12 still 48 degrees F. Review of the March 2007 logs for all 3 medication refrigerators revealed the following concerns: a. The 400 Hall log showed temperature readings were documented as taken only 5 times as of 3/6/07 instead of the 21 times required. b. The 300 Hall log showed temperature readings were documented as taken only 4 times through 3/6/07 instead of the 21 times required. c. The 200 Hall log showed temperature readings were documented as taken only 6 times through 3/6/07 instead of the 21 required times.	F 431		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on review of the medical record and staff interview, the facility failed to ensure laboratory orders were performed as ordered by the physician for two (#39, #43) of 15 sample residents. The findings were: 1. Review of the 9/1/06 physician orders for resident #39 revealed an order for HgbA1C to be done on 9/5/06. Review of the entire medical record revealed the test was not completed until 1/2/07. Interview with the resident care director on 3/7/07 at 10:20 AM revealed she was unsure why the order was missed. 2. Review of the 2/24/06 physician orders for resident #43 revealed an order for CMP (complete metabolic panel) to be done on	F 502	The nursing facility will ensure that laboratory services provided to our residents be of a quality and timely manner in order to meet the needs of our residents. This will be done by the following: 1) Resident #39's order for HgbA1C was completed. Resident #43's CMP was completed. 2) The Resident Care Director will implement a tracking tool for follow-up of physician-ordered tests. Charge nurses will monitor that ordered tests are obtained and delivered to lab as ordered. They will monitor that the results are received and placed in the resident's medical record in a timely manner. Any incomplete tests will be corrected upon discovery. 3) Staff will be in-serviced on the usage of the tracking tool. The tool will be turned into the Resident Care Director monthly. 4) Based on the tracking tool the Resident Care Director will monitor randomly	

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F 502	Continued From page 13 2/28/06. Review of the entire medical record revealed the test was not completed until 4/5/06. Interview with the resident care director on 3/7/07 at 10:20 AM revealed she was unsure why the order was missed.	F 502	selected resident records monthly for completeness and timeliness of ordered tests. These will be reported to the PI Steering committee on a quarterly basis.	
F 507 SS=D	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory reports were filed in the medical record for one (#41) of 15 sample residents. The findings were: Review of the physician's orders revealed an order for albumin in May 2006. Review of the entire medical record revealed the results of the test were not in the record. Interview with the resident care director on 3/7/07 at 10:20 AM confirmed the results were not in the medical record and that she had to obtain them from the laboratory.	F 507	1) Resident #41's albumin is currently in this resident's medical record. 2) The Resident Care Director will implement a tracking tool for follow-up of physician-ordered tests. Charge nurses will monitor that tests are obtained and delivered to lab as ordered. They will monitor that the results are received and placed in the resident's medical record in a timely manner. Any missing reports will be obtained upon discovery. 3) Staff will be in-serviced on the usage of the tracking tool. The tool will be turned into the Resident Care Director monthly. 4) The Resident Care Director will monitor randomly selected resident records monthly for completeness and timeliness of obtaining test results. These will be reported to the PI Steering committee on a quarterly basis.	4/21/07