POC accepted 3/16/07 jc

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OMB NO. 0938-0391

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

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 02/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 768, 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 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of documentation submitted to the state survey agency, the facility failed to notify the physician of a decline in swallowing ability for one	F 157	The facility will ensure the resident, the resident's family and/or legal representative, and resident's physician are notified when there has been a decline in condition, an accident which resulted in an injury requiring physician intervention, a significant change in mental, physical, psychosocial condition that may need an intervention from the physician as evidenced by: #38 reviewed A) A policy for Change of Condition has been put into place. This policy states the procedure to follow when a decline has been identified. See Attached Policy. Staff were educated on policy. There is a separate policy for emergencies. B) An inservice was given by a licensed speech pathologist for all nursing staff on February 16, 2007 instructing staff on signs and symptoms to watch for to indicate a decline in a resident's ability to swallow. This inservice will be made a regular part of the inservice schedule to ensure the deficient practice does not recur. All departments are to be notified when there is a change of condition so any changes can be made in an attempt to prevent risk of aspiration.	Mar. 9, 2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah C. Wood — TITLE: Administrator — (X6) DATE: 3-9-07

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 adequate 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.

MAR 09 2007 Changes made per phone on 3/16/07 @ 1630 with Deborah Wood, administrator and Jenelle Conlin

Wyoming Dept of Health Licensing and Surveys

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 786, 333 N BRIDGER AVE PINEDALE, WY 82941

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F 157	Continued From page 1 (#38) of three sample residents who exhibited increased difficulty with swallowing. Resident #38 experienced symptoms of aspiration, and then expired. The findings were: Review of the closed medical record for resident #38 showed a physician progress note dated 12/4/06 that documented the resident had "severe Alzheimer's." According to the significant change minimum data set (MDS) assessment dated 4/16/06, the resident was evaluated as having a swallowing problem and was totally dependent on staff for eating. Review of the physician summary orders dated January 2007 revealed the resident was prescribed an "As tolerated, pureed" diet on 1/6/04. Review of a dietary progress note dated 1/25/07 showed the registered dietitian documented "Nursing reports they are requesting cream of wheat or cream of rice at bkf [breakfast] and maybe other meals per reports of res [resident] difficulty in swallowing." On 1/27/07 a nursing note documented "Res had been choking- was being given juice at lunch.... To rm [room] res having audible gurgling - heard gurgling throughout lung fields upon auscultation (listening for sounds in the chest)." Review of a nurse practitioner progress note dated that same day revealed, "Called by nursing home for possible aspiration." The progress note further documented that nursing home staff called back within five minutes to report the "pt [patient] had expired." Documentation of staff interviews conducted by the facility on 1/31/06 (submitted to the state survey agency on 2/2/07) revealed LPN #1 stated the resident seemed "gurgly" at breakfast that	F 157	C) The Director of Nursing or Assistant Director of Nursing will randomly monitor residents weekly to watch for signs of resident difficulty in swallowing or other changes in condition and to ensure that staff is attentive to signs. The Consulting Registered Dietician will also observe meals and will inform the Dietary Manager during the visit closing conference of any problems observed regarding swallowing, in addition to skin or GI problems brought to her attention. Registered Dietician closing conferences will be documented. D) The Director of Nursing will review daily shift reports to watch for changes of condition and will audit charts for documentation of proper communication of those changes in accordance with facility policy. E) The nurse manager (Director of Nursing) and Dietary Manager will ensure proper communication has been completed and reported at the quarterly QAA meeting.	

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	535017	A. BUILDING _____ B. WING _____	C 02/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 758, 333 N BRIDGER AVE PINEDALE, WY 82941

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F 157	Continued From page 2 morning (1/27/07). In addition, LPN #2 said the resident had been having "...more difficulty swallowing." Interview with registered nurse #1 on 2/12/07 at 12 noon revealed the resident had a "severe swallowing problem" and within the two to three weeks prior to expiring, the resident started to "choke more frequently." Interview with CNA #1 on 2/13/07 at 1:20 PM revealed she fed the resident on a frequent basis over the past year. The CNA further commented that during the last two to three weeks prior to the resident's death, the resident started "gagging and coughing" more frequently while being fed. Interview with the director of nursing on 2/12/07 at 2:45 PM confirmed the resident's coughing exacerbated about three weeks prior to the resident's death. The following problems were noted in regard to physician notification of the resident's increased symptoms of declining swallowing ability: a. Review of the medical record showed no evidence the facility notified the physician of the resident's increased coughing and choking while being fed. b. Interview with the director of nursing (DON) on 2/12/07 at 2:45 PM confirmed the facility did not notify the physician. c. Further interview with the DON on 2/12/07 at 3:50 PM revealed the facility did not have a written policy for notifying a physician when a resident experienced a change in condition. The DON further stated that the physician should have been notified of this resident's increased symptoms of declining swallowing ability.	F 157		
F 272 SS=G	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	Continued From page 3 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 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 through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of documentation submitted to the state survey agency, the facility failed to conduct a comprehensive swallowing assessment for one (#38) of four sample residents identified by the facility as having impaired swallowing ability.	F 272	The facility will ensure a proper assessment by a speech pathologist of swallowing is performed on the residents that have difficulty swallowing when there are signs of increased difficulty in swallowing. As evidenced by: #38 agreed A) An inservice by a licensed speech pathologist for all nursing staff members was performed to instruct staff on signs and symptoms of increased difficulty in swallowing, positioning, optimal food and fluid consistency, and safe feeding techniques. This will ensure difficulty in swallowing is adequately assessed and will be addressed by further evaluation. B) A nursing inservice was held with nursing staff to outline the facility definition of comfort care, to include evaluation and assessment of swallowing to prevent aspiration. C) The Director of Nursing will review daily shift reports to watch for changes of condition that require further assessment. Charts will be reviewed by the Director of Nursing of identified residents to ensure proper	Mar. 1, 2007

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 700, 333 N BRIDGER AVE PINEDALE, WY 82941

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F 272	Continued From page 4 Resident #36 experienced symptoms of aspiration and then expired. The findings were: Review of the closed medical record for resident #36 revealed a face sheet that documented one of the resident's diagnoses was Alzheimer's disease. A physician's progress note dated 12/4/06 assessed the resident has having "severe Alzheimer's." Review of the physician's summary orders, dated January 2007, revealed the resident was prescribed an "As tolerated, pureed" diet on 1/8/04. According to the significant change minimum data set (MDS) assessment dated 4/16/06, the resident was evaluated as having a swallowing problem, left 25 percent of food uneaten at most meals, received a mechanically altered diet, and had a stage IV pressure ulcer. In addition, the resident was totally dependent on staff for eating. According to Section V, Resident Assessment Protocol (RAP) Summary, a comprehensive assessment in the area of nutritional status was triggered. The RAP summary further noted the documentation of the assessment was located in a 4/6/06 nutritional assessment. Review of the 4/6/06 nutritional assessment showed the resident's swallowing difficulties, and the mechanically altered diet, were not addressed. Interview with the certified dietary manager (CDM) on 2/13/07 at 9:15 AM confirmed the assessment did not address the resident's swallowing impairment or food texture needs. Further medical record review showed no evidence a comprehensive swallowing assessment was initiated for this resident. Interview with and the CDM on 2/12/07 at 3:15 PM, and the director of medical records on 2/12/07 at 3:30 PM, confirmed there was no	F 272	assessment was conducted and communicated. Residents with orders for comfort care will have chart reviews monthly by the care plan team to ensure care coincides with facility policy. D) The nurse manager (Director of Nursing) will report effectiveness of these measures to improve assessment at the quarterly QAA meeting.	

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F 272	Continued From page 5 comprehensive swallowing evaluation in the medical record. The following problems were noted related to the lack of assessment of the resident's swallowing function, positioning needs, optimal food and fluid consistency, safe feeding techniques and monitoring for symptoms of aspiration: a. Review of a dietary progress note dated 1/25/07 revealed the registered dietitian documented "Nursing reports they are requesting cream of wheat or cream of rice at bkf [breakfast] and maybe other meals per reports of res [resident] difficulty in swallowing." b. On 1/27/07 a nursing note documented "Res had been choking- was being given juice at lunch.... To rm [room] res having audible gurgling - heard gurgling throughout lung fields upon auscultation (listening for sounds in the chest)." c. Review of a nurse practitioner progress note dated that same day revealed "Called by nursing home for possible aspiration." The progress note further documented that nursing home staff called back in less than five minutes to report the "pt [patient] had expired." d. Documentation of staff interviews conducted by the facility on 1/31/08 and submitted to the state survey agency on 2/2/07 revealed licensed practical nurse (LPN) #1 stated the resident seemed "gurgly" at breakfast that morning (1/27/07) and "had been having an intermittent cough for quite a while." In addition, LPN #2 said the resident had been having "...more difficulty in swallowing." e. Interview with registered nurse #1 on 2/12/07 at 12 noon revealed the resident had a "severe swallowing problem" and within the last two to three weeks prior to expiring, the resident started to "choke more frequently."	F 272		

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	530017	A. BUILDING _____ B. WING _____	C 02/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 780, 333 N BRIDGER AVE PINEDALE, WY 82941

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F 272	Continued From page 6 f. Interview with the director of nursing (DON) on 2/12/07 at 2:45 PM confirmed the resident's coughing exacerbated about three weeks prior to death. g. Interview with certified nurse aide (CNA) #1 on 2/12/07 at 1:20 PM revealed she fed the resident on a frequent basis over the past year. The CNA stated that during the two to three weeks immediately preceeding the resident's death, the resident started "gagging and coughing" more frequently while being fed. When questioned in regard to an individualized plan for safe feeding techniques, proper positioning, and optimal food and fluid consistency, the CNA said she was not aware of a specific plan. The CNA stated that when feeding this resident she "just used common sense." h. Interview with the administrator on 2/12/07 at 9:20 AM, and the director of nursing on 2/12/07 at 11:05 AM, revealed the resident began experiencing swallowing problems in 2002. At that time, a request was made for a speech therapy evaluation; however, the physician declined to order the assessment. Interview with both the administrator and the DON on 2/13/07 at 8:30 AM revealed the facility had not requested another swallowing evaluation since the 2002 request, because the resident was receiving "comfort care." Interview with the DON on 2/12/07 at 2:45 PM revealed an assessment of swallowing abilities to assist the direct care staff with safe feeding techniques, positioning, optimal food and fluid consistencies, and monitoring for symptoms of aspiration would be appropriate for a resident receiving "comfort care."	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS	F 280		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

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F 280	Continued From page 7 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a care plan for two (#38 and #6) of four residents identified as having a swallowing problem. The care plan for resident #38 did not address the resident's swallowing problem or the individualized goals and approaches related to the swallowing impairment. In addition, the care plan for resident #6 was not accurate. The findings were: 1. Review of the closed medical record for resident #38 revealed a face sheet that documented one of the resident's diagnoses was Alzheimer's disease. A physician's progress note dated 12/4/06 assessed the resident has having "severe Alzheimer's." Review of the physician	F 280	The facility will ensure comprehensive care plans will address resident #6 and his specific needs and will address issues specific to all residents. This will be evidenced by: #38 expired A) All care plans will be reviewed quarterly for symptoms and/or changes of condition. At care plan meetings quarterly reviews of care plans will be conducted out-loud with the care plan team to ensure changes and misstatements will be updated to ensure accuracy of the care plan and to ensure the care plan is individualized for each resident. Care plans will be altered to meet the needs of the resident and to ensure the resident is attaining goals set to prevent a decline or change of condition. B) Inservice for nursing staff was conducted to instruct staff to make necessary changes to the care plan during review. The nurse making the change is to communicate changes to the MDS Coordinator. C) The Dietary Manager will hold an inservice to review the resident's care plans regarding	Mar. 1, 2007

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 782, 333 N BRIDGER AVE PINEDALE, WY 82941

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F 280	Continued From page 8 summary orders dated January 2007 revealed the resident was prescribed an "As tolerated, pureed" diet on 1/8/04. According to the significant change minimum data set (MDS) assessment dated 4/16/06, the resident was evaluated as having a swallowing problem, left 25 percent of food uneaten at most meals, received a mechanically altered diet, and had a stage IV pressure ulcer. In addition, the resident was totally dependent on staff for eating. The following was noted: a. Interview with the administrator on 2/12/07 at 9:20 AM, and the director of nursing on 2/12/07 at 11:05 AM, revealed the resident began experiencing swallowing problems in 2002. b. Review of a dietary progress note dated 1/25/07 showed the registered dietitian documented, "Nursing reports they are requesting cream of wheat or cream of rice at bkf [breakfast] and maybe other meals per reports of res [resident] difficulty in swallowing." c. On 1/27/07 a nursing note documented "Res had been choking- was being given juice at lunch.... To rm [room] res having audible gurgling - heard gurgling throughout lung fields upon auscultation (listening for sounds in the chest)." d. Review of a nurse practitioner progress note dated that same day revealed "Called by nursing home for possible aspiration." The progress note further documented that nursing home staff called back in less than five minutes to report the "pt [patient] had expired." e. Documentation of staff interviews conducted by the facility on 1/31/06 (submitted to the state survey agency on 2/2/07) revealed LPN #1 stated the resident seemed "gurgly" at breakfast that morning (1/27/07) and "had been	F 280	dietary needs of each resident. There will be a folder kept in the kitchen with a copy of each resident's dietary care plan. This will enable the staff to become familiar with each resident's dietary care plan. The Dietary Manager will monitor that the care plans have been read and signed off each quarter or as needed with changes accruing before the quarter. The Dietary Manager will report on this at each QAA. D) The Director of Nursing will ensure accuracy of the care plan by reviewing the care plans at the quarterly care plan meetings and at review of annual assessments and significant change of condition assessment reviews. E) The Director of Nursing will monitor the effectiveness of this procedure monthly and report results at the quarterly QAA meetings.	

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F 280	Continued From page 9	F 280		

having an intermittent cough for quite a while." In addition, LPN #2 said the resident had been having "...more difficulty in swallowing."

f. Interview with registered nurse #1 on 2/12/07 at 12 noon revealed the resident had a "severe swallowing problem" and within the last two to three weeks prior to expiring, the resident started to "choke more frequently."

g. Interview with the director of nursing (DON) on 2/12/07 at 2:45 PM confirmed the coughing exacerbated about three weeks prior to the resident's death.

h. Interview with CNA #1 on 2/12/07 at 1:20 PM revealed that she fed the resident on a frequent basis over the past year. The CNA further commented that during the two to three weeks prior to the resident's death, the resident was "gagging and coughing" more frequently while being fed. When questioned in regard to an individualized plan for feeding techniques, proper positioning, and optimal food and fluid consistency for this resident, the CNA said she was not aware of a specific plan. The CNA stated she "just used common sense" when feeding this resident.

Review of the care plan showed the resident's swallowing impairment was not listed as a problem. In addition, there were no individualized goals or approaches that addressed safe feeding techniques, proper positioning, optimal food and fluid consistencies, and monitoring for symptoms of aspiration. Interview with the DON on 2/15/07 at 2 PM confirmed the resident's swallowing problem and individualized goals and approaches to minimize the risk of aspiration, were not included on the resident's care plan.

2. Review of a neurology consultation dated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 708, 330 N BRIDGER AVE PINEDALE, WY 82941

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F 280	Continued From page 10 4/9/06 for resident #6 showed a diagnosis of progressive supranuclear palsy (a neurological disorder that affects swallowing ability). According to the significant change minimum data set (MDS) assessment dated 8/31/06, the resident was evaluated as having a swallowing problem, received a mechanically altered diet, and was totally dependent on staff for eating. Review of the physician's monthly summary orders, dated January 2007, revealed the diet order written on 8/23/06 for igus resident was: "As Tolerated, Pureed, Honey thickened liquids." Observation of lunch on 2/12/07 between 12:30 PM and 1 PM confirmed the resident received a pureed diet and thickened liquids and required total assistance with eating. Further observation revealed the resident coughed throughout the meal. Review of the resident's care plan showed the following inaccuracies: a. Two of the listed approaches for the problem of "Dietary/Potential for Aspiration" were a "Mechanical soft" diet and "Use plate guard with resident's plates." b. Interview with the DON on 12/12/07 at 2:15 PM revealed the resident had received a pureed diet for "quite some time," but for that same amount of time, was not capable of feeding him/herself with or without a plate guard. c. Interview with the certified dietary manager on 12/13/07 at 9:15 AM confirmed the care plan approaches were not updated when the diet consistency was changed and the resident was no longer capable of feeding him/herself.	F 280		
F 312 SS=G	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	336017	A. BUILDING _____ B. WING _____	C 02/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 533 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 312	Continued From page 11 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of documentation submitted to the state survey agency, the facility failed to assure one (#38) of four sample residents requiring assistance with eating, and evaluated as having a swallowing problem, received the necessary services to assure foods and fluids were provided as safely as possible. The resident's impaired swallowing ability was not assessed, nor was an individualized care plan developed to address the specific needs of this resident while consuming food and fluids. The resident experienced symptoms of aspiration and then expired. The findings were: Review of the closed medical record for resident #38 revealed the face sheet documented one of the resident's diagnoses was Alzheimer's disease. A physician progress note dated 12/4/06 assessed the resident has having "severe Alzheimer's." Review of the physician summary orders dated January 2007 revealed the resident was prescribed an "As tolerated, pureed" diet on 1/6/04. According to the significant change minimum data set (MDS) assessment dated 4/16/06, the resident was evaluated as having a swallowing problem, left 25 percent of food uneaten at most meals, received a mechanically altered diet, and had a stage IV pressure ulcer. In addition, the resident was totally dependent on staff for eating. According to Section V, Resident Assessment	F 312	The facility will ensure the quality of activities of daily living will be met for all residents. This will be evidenced by: #38 expired A) An inservice by a licensed speech pathologist for all nursing staff members was performed to instruct staff on signs and symptoms of increased difficulty in swallowing, positioning, optimal food and fluid consistency, and safe feeding techniques. This will ensure difficulty in swallowing is adequately assessed and will be addressed by further evaluation. B) A nursing inservice was held with nursing staff to outline the facility definition of comfort care, to include evaluation and assessment of swallowing and other activities of daily living. A policy for Change of Condition has been put into place. C) The Director of Nursing will review daily shift reports to watch for changes in ability to perform activities of daily living. Charts will be reviewed	Feb. 16, 2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	536017	A. BUILDING _____ B. WING _____	C 02/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 760, 323 N DRIDGER AVE PINEDALE, WY 82941

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F 312	Continued From page 12 Protocol (RAP) Summary, a comprehensive assessment in the area of nutritional status was triggered. Refer to F 272 in regard to the lack of a comprehensive swallowing assessment for resident #38. The following problems were noted: a. Review of a dietary progress note dated 1/26/07 showed the registered dietitian documented "Nursing reports they are requesting cream of wheat or cream of rice at bkf [breakfast] and maybe other meals per reports of res [resident] difficulty in swallowing." b. On 1/27/07 a nursing note documented "Res had been choking- was being given juice at lunch.... To rm [room] res having audible gurgling - heard gurgling throughout lung fields upon auscultation (listening for sounds in the chest)." c. Review of a nurse practitioner progress note dated that same day revealed "Called by nursing home for possible aspiration." The progress note further documented that nursing home staff called back in less than five minutes to report the "pt [patient] had expired." d. Documentation of staff interviews conducted by the facility on 1/31/06 and submitted to the state survey agency on 2/2/07 revealed LPN #1 stated the resident seemed "gurgly" at breakfast that morning (1/27/07) and "had been having an intermittent cough for quite a while." In addition, LPN #2 said the resident had been having "...more difficulty in swallowing." e. Interview with registered nurse #1 on 2/12/07 at 12 noon revealed the resident had a "severe swallowing problem" and within the last two to three weeks prior to expiring, the resident started to "choke more frequently." f. Interview with the director of nursing (DON) on 2/12/07 at 2:45 PM confirmed the coughing	F 312	by the Director of Nursing of identified residents to ensure proper assessment was conducted and services provided. Residents with orders for comfort care will have chart reviews monthly by the care plan team to ensure care coincides with facility policy and to ensure necessary services are provided for activities of daily living. D) The nurse manager (Director of Nursing) will report effectiveness of these measures to improve detection of service needs for activities of daily living at the quarterly QAA meeting.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 933 N BRIDGER AVE PINEDALE, WY 82941

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F 312	Continued From page 13 exacerbated about three weeks prior to the resident's death. g. Interview with CNA #1 on 2/12/07 at 1:20 PM revealed over the last year she fed the resident on a frequent basis. The CNA further commented that during the last two to three weeks prior to the resident's death, the resident started "gagging and coughing" more frequently while being fed. The CNA stated she was unaware of a specific plan for this resident that addressed feeding techniques, proper positioning during meals, or optimal food/fluid consistency. In addition, the CNA stated that when it came to determining how to, "safely feed the resident" she just used common sense. Refer to F 280 in regard to the lack of an individualized care plan for resident #38. Further interview with the DON on 2/13/07 at 2:45 PM revealed an assessment of swallowing abilities to assist the direct care staff with safe feeding techniques, positioning, optimal food and fluid consistencies, and monitoring for symptoms of aspiration would be appropriate for a resident receiving "comfort care."	F 312		