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

PRINTED: 04/18/2006
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
	535024	A. BUILDING _____ B. WING _____	04/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST CASPER, WY 82601

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have 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	F 225	Ftag 225 1. IMMEDIATE Resident #86 did not want the money to be replaced and it was determined that the resident's daughter may have taken, the resident refused to have the authorities contacted. 2. RISK A complete review of ~~the~~ all grievances will be done to ensure that each issue has been resolved, and the facility has completed and attained the information in a file. 3. SYSTEM In-service the DON/NHA/SSD on reporting misappropriation of property timely. Review the State Federal guidelines. Done by the NHA & or designee. • Review the grievance log X30 (4/6/06) days ensure that grievances, especially misappropriation of money have been: • Resolved timely • Appropriate authorities notified timely.	5-6-06

the money.

filed by all residents

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Arlea W Johnson	NHA	4-27-06

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.

APPROVED
APR 28 2006
WYOMING DEPT. OF HEALTH
HEALTH FACILITIES

Revised/approved with changes on pages 1, 3, 9, 11, 17 after T.C. with Ms. Arlea Johnson, Administrator on 5/11/06 at 3:45pm

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F 225	Continued From page 1 by: Based on medical record review, review of facility investigation documentation, and staff interview, the facility failed to assure an allegation of misappropriation of resident property was thoroughly investigated for one of one allegations (resident #86). In addition, the facility failed to notify a law enforcement agency or the Department of Family Services (DFS) in accordance with state law. The findings were: Review of social service's notes on 3/27/06 showed resident #86 stated she/he was missing $900. Review of the facility's investigation by the social service director (SSD), dated 3/27/06, showed the resident reported missing $900 on 3/25/06. The investigation showed the SSD interviewed the resident regarding the missing money. The investigation failed to show other residents or staff were interviewed, and did not show the facility notified a law enforcement agency or DFS. During an interview on 4/5/06 at 3:15 PM, the SSD stated there was no documentation to show other residents or staff were interviewed. She stated she interviewed only one other resident, and could not specifically say which staff she talked to. During an interview on 4/5/06 at 3:25 PM, the administrator and director of nursing (DON) stated there was no other documentation regarding the investigation. The administrator stated that neither law enforcement nor DFS were called by the facility. Review of the Rules and Regulations,	F 225	• Documentation is in place in a file Done by the NHA & or Designee. The grievance log will be updated weekly with any new grievances. Done by the NHA/SSD & or Designee. 4. MONITOR Weekly review of the grievance log to ensure that the documentation is attained and appropriate authorities contacted, will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	

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F 225	Continued From page 2 Department of Family Services, Adult Protective Services, Chapter 2, Section 1, revealed "...any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused...exploited...shall report the information immediately to a law enforcement agency or the Department....Law enforcement agencies include, but are not limited to, the following: (i) Municipal police; (ii) County sheriff's department; (iii) Highway patrol; or (iv) Medicaid Fraud Control Unit of the Attorney General's Office..."	F 225		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to assure staff utilized appropriate sanitation measures to disinfect contaminated equipment prior to resident use. In addition, multiple chairs throughout the facility were stained and appeared dirty. The findings were: 1. On 4/4/06 at 7:45 AM observation showed resident #19 was wet from mid-back to under the buttocks. There was a strong odor of urine in the room, the gown was off the resident's shoulders, and certified nurse aide (CNA) #75 confirmed the linens next to the resident's back and buttocks were saturated with urine. The CNA cleansed the resident's buttocks, but did not cleanse the	F 253	FT253 1.IMMEDIATE The sling identified was disinfected. Chairs throughout the facility were evaluated. A portion of the chairs ~~that were able to have stains~~ were able to have stains removed with a combination of cleaning solutions. 2. RISK No residents were affected by this deficient practice.	5-10-06

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F 253	Continued From page 3	F 253		

resident's back before placing the sling for the sit-to-stand lift next to the his/her back. When questioned immediately after the observation, CNA #20, who assisted with the resident's transfer, stated the lift and sling would be stored in the shower room. At 8:33 AM on 4/4/06, CNA #75 stated that sling would be used for all residents who utilized the lift. She further stated that sling would not be disinfected until the end of the day.

Interview with the director of nursing (DON) on 4/4/06 at 6:14 PM revealed the facility did not have a policy and procedure for disinfecting the sling in the above situation. However, the DON stated the sling should have been washed by housekeeping before it was used for other residents.

2. Observation from 4/3/06 through 4/6/06 revealed multiple chairs throughout the facility were stained and appeared dirty. On 4/6/06 at 9:12 AM, the director of housekeeping stated "every chair" was stained. The interview further revealed the chairs were cleaned and disinfected weekly, but the stains were permanent. On 4/6/06 at 9:30 AM, the administrator confirmed the chairs needed replaced as the stains could not be removed.

3.SYSTEM
Bids will be sought and money obtained to replace the chairs that can not be adequately cleaned. Chairs will be inspected daily and routinely cleaned weekly and PRN. Each resident needing to utilize a lift will have a sling. Lift slings will be cleaned when soiled before it's next use.

4. MONITOR
Review the continuing effectiveness of the cleaning of chairs and slings monthly. To be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate. Done by the NHA & or Designee.

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F 272 SS=D	483.20, 483.20(b) 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 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 and staff interview, the facility failed to provide a comprehensive assessment for one of 21 sample residents (#60). The findings were:	F 272	Ftag272 1. IMMEDIATE Resident #60 Bowel and bladder assessment was completed on 4/24/06, the determination from the results were as follows resident is unable to feel the urge to void. The care plan has been updated. 2. RISK Complete reviews of the bowel and bladder assessments of residents that are incontinent of bowel and bladder have been completed with necessary action taken. 3. SYSTEM Review the bowel and bladder policy with the bowel and bladder nurse to ensure the evaluations are to be complete and accurate. Done by the SDC & or Designee, monitored by the DON.	5-10-06

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F 272	Continued From page 5 Review of the 11/22/05 significant change Minimum Data Set (MDS) assessment showed resident #60 was continent of bladder with a urinary catheter. The subsequent 2/7/06 quarterly MDS showed the resident no longer had a catheter, and was frequently incontinent of bladder (incontinent daily). Review of the resident functional performance record for March 16-31, 2006 showed the resident was incontinent daily. Review of the medical record showed the only bladder assessment for this resident was done on 8/16/05, which documented the resident was continent at that time. There lacked evidence a bladder assessment was done after the catheter was removed. During an interview on 4/5/06 at 11:10 AM, the registered nurse (RN) assessment coordinator and licensed practical nurse (LPN) assessment coordinator stated there was not a more recent bladder assessment for this resident.	F 272	The B/B evaluation will be done for incontinent residents on: • Admission • Quarterly • Annually • Change of condition • Foley removal Care plans will be updated as needed. 4. MONITOR Weekly review of the bowel and bladder program to ensure that the documentation is completed and accurate To be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	

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F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED	F 274		

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interview, the facility failed to complete a significant change Minimum Data Set (MDS) assessment for two of nine sample residents (#19, #60) who required a significant change assessment. The findings were:

1. Review of the 11/22/05 significant change MDS assessment revealed resident #60 was continent of bladder, had a urinary catheter, and did not have weight loss. A comparison to the subsequent 2/7/06 quarterly MDS showed the resident was frequently incontinent of bladder, no longer had the catheter, and had a significant weight loss. During an interview on 4/5/06 at 10:20 AM, the licensed practical nurse (LPN) assessment coordinator confirmed the change in bladder continence and weight loss, and stated a significant change assessment should have been

Ftag 274

1. IMMEDIATE
Resident #60, & #19 Change of condition MDS was completed on 4/25/06 to reflect the residents current condition and needs.

2. RISK
A complete resident review of the MDS has been completed reviewing the following specific areas:

- Foley removal
- Declining ability to eat
- Changes in bladder incontinence
- Decline in ROM
- Residents that have improved in 2 or more areas
- Unplanned weight loss

If it is determined that the resident has had a decline/improvement in 2 or more areas a change of condition MDS will be completed to reflect the residents current condition.

3. SYSTEM
Re-In-service nursing staff on the 24-hour report.
Continue to review the 24H report in the morning meeting for change of condition.

5-10-06

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F 274	Continued From page 7 done. 2. Comparison of the 2/17/06 quarterly with the 11/17/05 significant change MDS assessment revealed resident #19 declined in eating ability (from limited to total assistance), improved in ambulation (from none to extensive assistance), and declined in range of motion. Interview with MDS coordinator #72 on 4/4/06 at 5 PM confirmed the changes and revealed a significant change assessment should have been done instead of the quarterly assessment on 2/17/06.	F 274	Continue to utilize the referral form for specific disciplines. Review the RFPR's/RDS previous MDS for any changes of condition reflecting, 2 or more changes being either positive or negative. • Removal of a Foley • Unavoidable weight loss • Changes in eating abilities • Changes in ambulation • Changes in ROM The Regional MDS Coordinator will in-service the MDS coordinators on the RAI change of condition. 4. MONITOR Daily review of patients will occur and a log kept of patients with a change in condition. This will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care in accordance with the written plans of care for 3 of 21 sample residents (#9, #19, #31). The findings were: 1. Review of the current care plan, dated 4/4/06, showed the following interventions for resident #31: reposition every two hours in the chair, TABS [motion alarm to alert staff] in wheelchair, and a bed sensor. The following concerns were identified regarding the failure to provide care in accordance with the plan of care:	F 282	Ftag 282 1. IMMEDIATE Resident #31 has since been: Repositioned q 2H and PRN and has no negative affects from the alleged deficient practice. The IDT determined that the TAB	5-10-06

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F 282	Continued From page 8	F 282		

a. Observation of the resident on 4/3/06 from 4:20 PM until 7:30 PM (2 hours 60 minutes) and again on 4/4/06 from 7 AM until 9:40 AM (2 hours 40 minutes) showed the resident was not repositioned in the wheelchair. During an interview on 4/5/06 at 9:55 AM, the wound care registered nurse (RN) stated the resident could not reposition himself/herself in the wheelchair. The RN stated repositioning would include transferring the resident to bed or to the toilet, or off-loading [get pressure off wound] for at least 60 seconds.

b. Observation of the resident on 4/4/05 at 7:55 AM and again at 5:06 PM revealed the resident was in the wheelchair. The TABS alarm was not on the wheelchair. During an interview on 4/5/06 at 2:50 PM, the director of nursing (DON) stated the resident was supposed to have a TABS alarm in the wheelchair.

c. Observation on 4/5/06 at 2:25 PM revealed the resident was in bed. The bed sensor was not hooked up (the TABS box was still on the wheelchair, and the cord from the bed was laying on the floor, not hooked into the box). On 4/5/06 at 2:50 PM, the DON stated the resident should have a bed sensor. On 4/5/06 at 3 PM, the DON went with the surveyor to the resident's room. The resident was in bed, and the bed sensor was not hooked up. The DON confirmed the bed sensor was not hooked up.

2. Review of the 2/17/06 quarterly Minimum Data Set (MDS) assessment revealed resident #19 was totally incontinent of urine, and according to the 2/20/06 care plan, staff were to toilet him/her before and after meals, at bedtime, and as needed. Interview with certified nurse aide (CNA) #42 on 4/3/06 at 7 PM revealed the resident could

alarm was not needed and it was discontinued on 4/7/06.
Resident #9 leg straps were immediately placed on resident's leg toposition the Foley.
Resident #19 was given a shower on 4/4/06. CNA #42 was inserviced re the importance of following the ca plan for res #19,
2. RISK.
A complete review of the charts has been done on the following items:

- Utilizing the RDS (Resident Data Set) to determine who requires repositioning.
- To identifying residents who requires a TAB's and sensor alarm.
- To identify residents with Foley catheters that require leg straps for prevention of pulling motions.
- Review residents that are incontinent and require Pericare.

3. SYSTEM
In-service nursing staff on the following:
*Repositioning residents timely
*Catheter straps in place to prevent pulling
*TAB's in place for prevention of falls

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F 282	Continued From page 9 make his/her needs known to staff. Observation on 4/4/06 at 7:45 AM revealed the resident was not toileted or asked about using the bathroom when assisted out of bed for breakfast. Interview with CNA #63 on 4/4/06 at 9:55 AM revealed she assisted the resident to bed after breakfast. However, the CNA stated she did not toilet the resident or ask if s/he needed to use the bathroom. 3. Review of the care plan dated 3/20/06 showed resident #9 utilized a urinary catheter, and staff should, "anchor catheter to prevent excessive tension [and] secure catheter to facilitate flow." Observation on 4/3/06 at 7:15 PM showed CNA #66 assisted the resident to and from the bathroom and with preparations for bed. During the observation, the resident's indwelling urinary catheter swung free, and the resident repeatedly instructed the CNA to take care with the "tube" (indwelling urinary catheter) as it "hurts my bladder" when pulled. During an interview immediately after the observation, the CNA stated the facility did not have bands to secure the catheter tubing. However, interview with the unit manager, registered nurse #35, revealed catheter leg bands were available in the medication room.	F 282	*On the P & P Lipincott Policy & Procedure pp. 88Pericare.To be done by SDC or designee. Review and make a list on the following residents needs: *Repositioning residents timely *Catheter straps in place to prevent pulling *TAB's in place for prevention of falls *Residents that require total incontinent care To be done by the DON/ADON & or Designee. Do random weekly reviews to ensure staff are providing adequate Pericare and following the policy & procedures. Done by the SDC & or Designee. Do random daily rounds to ensure that the following are in place: *Timely repositioning of the residents *TAB's monitors *Foley Leg straps 4. MONITOR Weekly review of the audits to ensure that the plan of care for residents at risk for this deficient practice are monitored. This will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	

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F 312 SS=D	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 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of policies and procedures, the facility failed to assure staff provided appropriate perineal (incontinence) care for one (#19) of six incontinent, dependent residents. The findings were: On 4/4/06 at 7:45 AM observation showed resident #19 was wet from mid-back to under the buttocks. There was a strong odor of urine in the room, the gown was off the resident's shoulders, and certified nurse aide (CNA) #75 confirmed the linens next to the resident's back and buttocks were saturated with urine. The CNA cleansed the resident's buttocks, but did not cleanse the resident's anterior groin, perineum, or back. Interview with the director of nursing (DON) on 4/4/06 at 6:14 PM revealed the resident's groin, perineum, and back should have been cleansed. According to the facility's undated policy and procedure related to incontinence care, perineal care "includes care of the external genitalia and the anal area" and should be performed "...after urination..."	F 312	Ftag 312 1. IMMEDIATE Resident #19 a shower was given to the resident on 4/4/06 ~ CNA #75 was inserviced regarding importance of following facility policy/procedure relative to incont. care 2.RISK A complete review of resident charts was completed to identify residents that are incontinent and require assist with Pericare. 3. SYSTEM In-service nursing staff on the appropriate technique for peri-care, utilizing the policy & procedure (Lipincott pp88) Nursing staff will do return demonstration of the peri-care. Done by the SDC & or Designee. Do random weekly audits of peri-care to ensure staff is using appropriate technique. Done by the SDC & or Designee, 4. MONITOR Weekly review of the audits and their outcomes will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	5-6-06

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	535024	A. BUILDING _____ B. WING _____	04/06/2006

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F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy review, and staff interview, the facility failed to provide repositioning assistance for one of three sample residents (#31) with a pressure sore. The findings were: Review of the 3/28/06 quarterly Minimum Data Set (MDS) assessment showed resident #31 had a stage 2 and stage 3 pressure sore. Review of the pressure ulcer record showed that on 3/29/06 the resident had a stage 2 pressure ulcer to the right buttock, and a stage 2 pressure ulcer to the right malleolus (outside ankle). Observation on 4/5/06 at 7:07 AM showed the resident had a stage II pressure sore to the right buttock, approximately 2 centimeters (cm) in diameter. Review of the current care plan, dated 4/4/06, showed the resident was to be repositioned every two hours in the chair. However, observation of the resident on 4/3/06 from 4:20 PM until 7:30 PM (2 hours 50 minutes) and again on 4/4/06 from 7 AM until 9:40 AM (2 hours 40 minutes) showed the resident was not repositioned in the wheelchair. During an interview on 4/5/06 at 9:55 AM, the wound care registered nurse (RN) stated	F 314	Ftag 314 1. IMMEDIATE Resident #31 has since been: • Repositioned q 2H and PRN and has no negative affects from the alleged deficient practice. Resident's pressure ulcer was determined as being healed on 4/19/06. 2. RISK A complete review of the charts has been completed utilizing the RDS (Resident Data Set) section on risk for pressure ulcers to determine who is at risk for pressure ulcers and that appropriate action for prevention has been implemented. 3. SYSTEM In-service nursing staff on the 10-step program (skin). Done by the SDC & or Designee. In-service staff on the policy and procedure for repositioning and skin care. Develop a turning schedule: ➢ 10-4 face the door ➢ 6-2 face the view ➢ Meals & snacks on your back (8-12) Do random daily audits to ensure that the residents that require repositioning are turned timely	5-12-06

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F 314	Continued From page 12 the resident could not reposition him-/herself in the wheelchair. The RN stated repositioning would include transferring the resident to bed or to the toilet, or off-loading [get pressure off wound] for at least 60 seconds. Review of the facility's policy on skin care (from Nursing Procedures, fourth edition, 2004, Lippincott, Williams, & Wilkin) showed "...successful pressure ulcer treatment involves relieving pressure...treatment includes methods to decrease pressure, such as frequent repositioning to shorten pressure duration..."	F 314	Done by the IDT members. 4. MONITOR Weekly review of the audits will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that 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, and staff interview, the facility failed to consistently implement care planned interventions for one of 13 sample residents (#31) who had a history of falls. The findings were: Review of a 12/18/05 history and physical showed resident #31 suffered a fractured femur as a result of a fall from bed. Review of the 12/21/05 admission orders showed the resident had a fractured femur. Review of the 1/13/06 admission Minimum Data Set (MDS) assessment revealed the resident fell in the past 30 days, and the past 31-180 days. Review of the 12/21/05 fall risk assessment showed the resident was at risk for	F 324	Ftag 324 1. IMMEDIATE Resident #31 the TAB's alarm on the chair bed and floor, the IDT determined that it was not needed and it was discontinued on 4/7/06. 2. RISK A complete review of the charts has been done on the following item: *To identifying residents who require a TAB's/ sensor alarm. 3. SYSTEM In-service nursing staff on the placement and utilization of the TAB's monitor & sensor alarms for prevention of accidents Place a list of residents that require a TAB's unit or sensor alarm place in the TAR's (Treatment Assessment Record)/RFPR's (Resident	5-10-06

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F 324	Continued From page 13 falls. Review of the current care plan, dated 4/4/06, showed interventions to prevent falls included the TABS [motion alarm to alert staff] in wheelchair, and a bed sensor. The following concerns were identified regarding the failure to implement interventions: a.. Observation of the resident on 4/4/06 at 7:55 AM and again at 5:05 PM revealed the resident was in the wheelchair. The TABS alarm was not on the wheelchair. During an interview on 4/5/06 at 2:50 PM, the director of nursing (DON) stated the resident was supposed to have a TABS alarm in the wheelchair. b. Observation on 4/5/06 at 2:25 PM revealed the resident was in bed. The bed sensor was not hooked up (the TABS box was still on the wheelchair, and the cord from the bed was lying on the floor, not connected into the box). On 4/5/06 at 2:50 PM, the DON stated the resident should have a bed sensor. On 4/5/06 at 3 PM, the DON went with the surveyor to the resident's room. The resident was in bed, and the bed sensor was not connected. The DON confirmed the bed sensor was not connected.	F 324	Functional Performance Record). Done and monitored by the DON/ADON & or Designee. The IDT members will do random daily reviews to ensure that the residents that require a TAB's monitor or sensor alarm have it in place. 4. MONITOR Weekly review of the audits will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	
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 review	F 371	Ftag371 1. IMMEDIATE In-service of cook #1 was completed. 2. RISK No residents were affected by this deficient practice. 3. SYSTEM In-service dietary staff on the appropriate technique for handwashing, utilizing the policy & procedure.	5-10-06

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F 371	Continued From page 14 of policies and procedures, the facility failed to ensure dietary staff used acceptable handwashing procedures. The findings were: Observation on 4/4/06 at 7:15 AM revealed cook #1 wore disposable gloves while working with raw ground beef. The cook discarded the soiled gloves, and without washing her hands, put on new gloves and prepared a resident's breakfast from the steamtable. Again at 7:20 AM the cook removed her soiled gloves after working with raw ground beef, and without washing her hands, put on new gloves and served several residents their breakfasts. Interview with the dietary manager on 4/4/06 at 3:40 PM confirmed the cook should have washed her hands before putting on new gloves. According to the facility policy and procedure, taken from Lippincott, Williams, and Wilkins "Nursing Procedures Fourth Edition." Hands should be washed, "after working with raw food" and "Always wash hands after removing gloves." According to Food Code 2005, U.S. Public Health Service, 2-301.14: "Food employees shall clean their hands and exposed portions of their arms...(G) When switching between working with raw food and working with ready-to-eat food; (H) Before donning gloves for working with food; and (I) After engaging in other activities that contaminate the hands."	F 371	Dietary staff will do return demonstration of handwashing. Done by the SDC & or Designee. Do random weekly audits of handwashing to ensure staff is using appropriate technique. Done by the SDC & or Designee, 4. MONITOR Weekly review of the audits will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	

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F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure timely physician visits for two of 21 sample residents (#17, #38). The findings were: Review of the face sheet showed resident #17 was admitted to the facility on 9/3/02. Review of the active medical record showed no evidence of physician's visits. On 4/6/06 at 10:35 AM the director of nursing (DON) stated the resident had not been seen by a physician in the past 60 days as required. Review of the face sheet revealed resident #38 was admitted to the facility on 10/20/03. Review of the active medical record showed no evidence of physician's visits. On 4/6/06 at 10:35 AM the director of nursing (DON) stated the resident was not seen by a physician in the past 60 days as required.	F 387	Ftag 387 1. IMMEDIATE Resident #17 & 87 were taken to the physician office on 4/6/06 and seen by the physician. 2. RISK Do a complete review of resident charts for timely physician visits. 3. SYSTEM In-service the MR on the regulation for physician visits. Done by the NHA & or Designee. Make appointments for residents whose physician do not visit timely. Done by the Van Driver monitored by Medical Records. Do monthly reviews of the physician visits to ensure they are done timely. Done by Medical Records. Random weekly chart checks to ensure that the residents are being seen by the physician's timely will be done. Done by the NHA & or Designee. 4. MONITOR Weekly review of the audits will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	5-10-06

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F 431 SS=D	483.60(d) LABELING OF DRUGS AND BIOLOGICALS	F 431		

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

This REQUIREMENT is not met as evidenced by:

Based on random observation, staff interview, and review of policies and procedures, the facility failed to assure medications in one of two medication carts were labeled according to accepted professional principles. Medications for resident #107 did not contain expiration dates on the labels. The findings were:

On 4/5/06 at 9:37 AM review of the medications in the north medication cart showed that medication bottles containing Potassium, Cardura, and Bumetanide for resident #107 did not include expiration dates on the labels. Interview with licensed practical nurse # 54 revealed the medications were used daily for the resident and confirmed the lack of expiration dates. Interview with the director of nursing (DON) on 4/5/06 at 11 AM revealed she verified the lack of expiration dates with the pharmacy. Review of the facility's April 2005 policy and procedure,"Medication Management," showed, "Drugs that have been dispensed for a resident's use, and that are labeled in conformance with state and federal law, may be furnished to that resident..." According to the Wyoming Pharmacy Act, Rules and Regulations, printed March 2003, "all unit dose or unit of issue packaging shall be labeled

Ftag 431

1. IMMEDIATE All medications for Res #107 have expiration dates on the label
~~Resident # 107 the medications were given had no expiration dates on the label.~~ No negative outcome from the alleged deficient practice.

2. RISK
Do a complete audit of the med cart for medications without expiration dates. Action to be taken immediately.

3. SYSTEM
In-service nursing staff on checking for expiration dates.
Random weekly cart checks will be done to ensure that medications have expiration dates. Done by the DON/ADON.

4. MONITOR
Weekly review of the cart audits will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.

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F 431	Continued From page 17 as follows:...Manufacturer's expiration date..."	F 431		
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of policies and procedures, the facility failed to assure staff handled linens in such a manner as to prevent the spread of infection. The findings were: On 4/5/06 at 3:50 PM observation showed employee #73 wore disposable gloves while working in the dirty laundry area. The employee stated he had separated a load of dirty laundry and loaded it into the washer. Without washing his hands after removing the gloves, the employee entered the clean area and resumed folding the clean laundry. Interview with the employee immediately after the observation confirmed he had not washed his hands. Furthermore, at 4 PM on 4/5/06, the employee reiterated he never washed his hands after removing his gloves when working in the laundry area. On 4/6/06 at 9:12 AM, interview with the director of housekeeping, who was also responsible for the laundry, revealed staff should wash their hands after removing gloves to "prevent spread of infection." Review of the facility's April 2005 policy and procedure, "Sorting	F 445	Ftag 445 1.IMMEDIATE In-service of employee #73 was completed 2. RISK No residents were affected by this deficient practice. 3. SYSTEM In-service the laundry/housekeeping staff on the appropriate technique for handwashing, utilizing the policy & procedure. Laundry/housekeeping staff will do return demonstration of handwashing. Done by the SDC & or Designee. Do random weekly audits of handwashing to ensure staff is using appropriate technique. Done by the SDC & or Designee. 4. MONITOR Weekly review of the audits will be reviewed by the QA/A Committee for recommendation and continued compliance. Review monthly X 3-months and re-evaluate.	5-10-06

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F 445	Continued From page 18 & Washing Laundry," confirmed hands should be washed thoroughly after removal of gloves.	F 445		