PRINTED: 06/29/2006
FORM APPROVED
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 _____	06/15/2006

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 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure dignity was maintained for two (#2, #16) of nine sample residents. The findings were: 1. Observation of the evening meal on 6/12/06 at 6:53 PM showed resident #2 spilled his/her glass of milk (which contained approximately 160 cubic centimeters) on the table. Certified nurse aide (CNA) #24 was seated at the table across from the resident. The CNA offered the resident another glass, but neither the CNA, nor any other staff, cleaned the milk off the table for the duration of the meal observation (ending at 7:05 PM). The milk was left on the table while the resident finished eating his/her meal along with two tablemates. 2. Review of the 3/28/06 quarterly and the 4/6/06 significant change Minimum Data Set (MDS) assessment for resident #16 revealed s/he was totally dependent on staff for activities of daily living. Observation on 6/13/06 from 7:20 AM until 8 AM revealed the resident was seated in his/her reclining wheelchair in the lounge area. Continued observation revealed the resident's catheter tubing and catheter bag were exposed to view of the public. Interview with CNA # 15 on 6/13/06 at 4:10 PM revealed the catheter bag should have had a cover and the resident should have had a	F 241	◦ Staff will receive training related to dignity – including cleaning up spills and/or accidents made by the resident and the need to hide catheter bags and tubing from sight. ◦ Residents with catheters will be identified and caregivers reminded to keep catheter items discreetly covered. ◦ The Housekeeping Director will ensure that spill clean up items are always readily available in the dining room. ◦ Dignity training will be part of the semi-annual resident rights and abuse inservices for all staff. Random weekly checks will be performed by the Administrator and Director of Nursing to monitor the effectiveness of the education, to provide reminders for staff, and to ensure that practices retain a resident's dignity. ◦ Results of the weekly checks will be reported to the Quality Assessment and Assurance Committee.	7/5/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah J Wood | TITLE: Administrator | (X6) DATE: 7/10/06

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.

Changes made per phone on 7/19/06 @ 1630 c Deborah Wood Administrator
JUL 20 2006 Carol Jarrell Corbin

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7/19/06 JC

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F 241	Continued From page 1 lap blanket to cover the exposed catheter tubing.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide activities to meet the needs of one (#16) of nine sample residents received daily the recommended one to one activities. The findings were: Review of the 3/28/06 activities assessment for resident #16 revealed s/he was to receive one to one visits daily. Review of the 4/13/06 care plan revealed the goal for the resident was to have his/her senses stimulated one time daily during one to one visits. Continued review of the care plan revealed approaches identified for goal accomplishment included: schedule one to one visits around rest periods, rub lotion on the resident's arms and hands, stimulate the resident by gently rubbing legs or shoulders, engage in other stimulation such as: scent, smell, and taste, and pick up the resident after breakfast or lunch for one to one visits. The following concerns were identified: a. Review of the activity records for 5/06 revealed the resident received one to one	F 248	◦ A mandatory activity in-service will be held on July 6, 2006 pertaining to the importance of following the care plan, and initiating 1-1 visits for those low functioning individuals who are care planned to be visited with on a daily basis. ◦ The Activities Director will monitor the occurrence of 1-1 visits by creating an additional sign-off sheet for daily 1-1 visits. Activity staff will complete the document each day, and submit it to the Activities Director at the end of their shift. ◦ The Activities Director will incorporate and schedule additional 1-1 visits into the activity calendar. ◦ This plan of correction will be monitored and re-assessed at the Quality Assessment and Assurance (QAA) Committee quarterly.	7/6/06 for resident #16 (JC)

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F 248	Continued From page 2 activities only 8 of the 31 days. b. Review of the 6/06 activity record revealed the resident had received only 4 days of one to one activities during the first 15 days. During an interview on 6/14/06 at 2 PM, the activity director stated "I guess we've [we have] been lax with the resident's one to ones." She further stated "it is hard to find a time to be with him/her." c. Periodic observations on 6/13/06 from 7 AM until 6 PM and on 6/14/06 from 8 AM until 5 PM revealed no one to one activities were provided for the resident.	F 248		
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 interview, the facility failed to maintain walls and tile flooring in order to promote a comfortable interior for residents. The findings were: 1. Observation on 6/13/06 at 7 AM, 10:45 AM, and 10:52 AM, and on 6/14/06 at 5:05 PM, revealed the following areas of walls which were in need of painting (the areas were touched up with spackle, but were not painted): a. In room 1, there was an area of the wall to the right of the headboard approximately 32 inches by 10 inches and an area 5 inches by 1 inch on the wall to the left of the closet. b. In room 12, there were three areas above	F 253	◦ Rooms 1, 2, 12, 105, 201, and the wall in the corridor to the left of the room marked LABORATORY SERVICES will be painted. The tile(s) missing from the Howard Smith Dining Room floor will be replaced. ◦ Wall repairs will be documented on Maintenance Work Order forms and them passed from the Maintenance Director to the Housekeeping Director to ensure that painting over of wall repairs is completed in a timely manner. Work orders will be signed off by both Directors and then forwarded to the Administrator. ◦ Timeliness of painting over of wall repairs will be reviewed in the Quality Assessment and Assurance meeting, with results presented by the House-	7/7/06

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F 253	Continued From page 3 the bed closest to the door, with the largest area measuring 8 inches by 5 inches. c. In room 2, there were three areas above the bed closest to the door, with the largest area measuring 6 inches by 7 inches. In addition, there was an area on the wall to the left of the closet measuring 4 inches by 1.5 inches where the drywall was cracked. d. In room 201, an area of the wall behind the recliners, measuring approximately 5 feet long. e. In room 105, an area of the wall behind the recliner measuring approximately 5 feet long. f. On the wall to the left of the door labeled "Laboratory Services" there were three areas, with the largest measuring approximately 1.5 inches. 2. Observation on 6/13/06 at 10:10 AM revealed an area measuring approximately 5 inches by 3 inches where the tile flooring was missing near the rear exit door in the Howard Smith Dining Room. 3. During a tour on 6/14/06 at 2:15 PM, the maintenance director stated holes in the walls had been patched, but had not been painted. He stated some of the areas had been there "a while." He stated he did not have a timeframe for painting the areas, other than this "summer". On 6/14/06 at 3:15 PM, the administrator stated the painting of resident rooms was done by facility staff.	F 253	keeping Director. ◦ The Housekeeping Director will monitor this procedure effectiveness by performing weekly walk thrus to determine which rooms are in need of paint or tile repairs. ◦ Findings by the Housekeeping Director will be reported to the Administrator and reported to the QAA Committee at the quarterly meetings.	

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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 observation, staff interview, and medical record review, the facility failed to ensure the care plan was updated for one (#16) of ten sample residents. The findings were: Observation on 6/12/06 at 6 PM revealed the resident had a foley catheter in place. Review of the 4/13/06 care plan revealed the plan was not updated to reflect the insertion and care of the catheter. Interview with the assistant director of nursing on 6/15/06 at 8:50 AM confirmed the care plan was not updated to reflect the catheter.	F 280	◦ Review of Resident #16's care plan revealed the care plan had not been updated as evidenced by observation on 6/12/06 at 1800pm. The care plan did not reflect the insertion and care of an indwelling catheter. The DON and MDS Coordinator will review Resident #16's chart and ensure the catheter care is included and appropriate. ◦ The DON and MDS Coordinator will monitor through bi-monthly review of all residents with indwelling catheters to ensure the indwelling catheter is appropriate and will review the care plan of all residents with indwelling catheters to ensure the care plan is correct. All admission and readmission care plans will be reviewed by the care plan team within 14 days of admission to ensure that the care plan is in place and appropriate. ◦ Licensed nursing staff will be instructed to fill out a communication form and give it to the DON and MDS Coordinator to ensure changes in resident care are communicated timely to ensure the proper changes can be made to the care plan. ◦ This procedure will be reviewed in the QAA Committee quarterly meeting.	7/15/06

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F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure professional standards were followed for two (#9, #16) of nine sample residents in a variety of areas. The findings were: 1. Review of the medical record showed resident #9 had a fall on 3/15/06. According to the nursing notes dated 3/15/06 at 7 PM, the resident fell hitting the back of his/her head on a bedside table. The resident stated s/he was dizzy. Interview with the administrator on 6/15/06 at 9:20 AM confirmed a physical assessment was not included in the nursing notes, but was completed on an incident report (not part of the medical record). However, there was no evidence in the medical record or the incident report that any neurological checks or assessment was completed. According to "The Lippincott Manual of Nursing Practice", seventh edition, 2001, page 1070, assessment of a head injury included "history of injury, level of consciousness [neurological checks], vital signs,..." 2. Review of the 4/06 signed physician's orders for resident #16 revealed two conflicting orders for repositioning the resident in regard to his/her pressure sore on the right hip. Review revealed on order instructed "Clock turning schedule 12-2:00 supine, 2:00-4:00 left side lying, 4:00-6:00 right side lying, 6:00-8:00 supine, 8:00-10:00 left side lying, 10:00-12:00 right side	F 281	1. ◦ Neurological checks are to be performed on all residents that have had a fall and hit his/her head. The facility will ensure neurological checks will be completed by instructing nursing staff to perform neurological checks on all head injuries based on facility policy. Nursing staff will be instructed to document neurological checks on the incident report and in the medical record. ◦ The DON will monitor the performance of neurological checks for head injuries by looking for evidence on each incident report received and confirming the checks were documented in the medical record. The DON will report findings to the QAA Committee. 2. ◦ The MDS Coordinator will review physician orders on Resident #16 for any duplicate orders or contradicting orders on a monthly basis. The MDS Coordinator will contact Resident #16's physician to see which order is to be followed. The MDS Coordinator will then discontinue the order the physician does not want to continue. ◦ The MDS Coordinator will review physician orders bi-monthly to ensure that the orders do not contraindicate	7/15/06

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F 281	Continued From page 6 lying when in bed." The same monthly order sheet revealed an order that instructed "Pt. [patient/resident] needs to be kept off his/her rt. [right] hip..." because of a developing pressure sore. Interview with the ADON on 6/13/06 at 2:06 PM revealed she was unaware why there were two conflicting orders; one that instructed the resident be kept off the right hip and one that instructed the resident should lay on the right hip for a two hour period of time. The ADON further stated the order should have been clarified.	F 281	each other and will contact the physician to clarify the orders. ◦ The DON will monitor the effectiveness of this process by reviewing physician orders for patients once each quarter and reporting any findings to the Quality Assessment and Assurance Committee.	
F 282 SS=G	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 two (#2, #16) of nine sample residents. The facility's failure to follow the plan of care for resident #2 resulted in pain which was avoidable. The findings were: 1. Review of the 4/27/06 significant change Minimum Data Set (MDS) assessment showed resident #2 had pain on a daily basis which was at times excruciating. Review of the 4/27/06 Resident Assessment Protocol (RAP) narrative for pressure ulcers showed the resident had two	F 282	1. ◦ When a P.T. (physical therapist) is scheduled to assess the wounds to Resident #2's Lt. foot, P.T. will call nursing staff to inform them of when he/she will be over to change dressing to Lt. foot so licensed nursing staff can medicate Resident #2 30 minutes prior to dressing change. ◦ All physical therapists will be instructed to contact the charge nurse more than 30 minutes before a scheduled treatment to determine if any pretreatment procedures are necessary. All physical therapists will be instructed to confirm the pretreatment procedures were completed prior to beginning treatment. Patients experiencing excessive pain will have treatment	7/15/06

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F 282	Continued From page 7 stage 4 ulcers on the left foot. Review of physician's orders showed the resident had the following pain medication ordered on a prn (as needed) basis: MS Contin 15 milligrams (mg) twice per day as needed, and Hydrocodone BIT/APAP 7./500 one to two tabs as needed every four to six hours. Review of the care plan dated 5/10/06 showed the resident had pain resulting from impaired skin integrity. The care plan stated "Administer analgesics 30 minutes before dressing change to foot." The following concerns were noted regarding the facility's failure to follow the plan of care: a. Observation on 6/13/06 at 9:35 AM showed physical therapists (PTs) #1 and #2 provided wound care to the left heel and left dorsal foot. The dorsal wound on the foot was approximately 1 cm in circumference. PT #1 stated the wound could not be staged because there was collagen present, and was not sure what was underneath. PT #1 did sharp debridement of the dorsal wound, and put a new dressing on it. During the wound care, the resident cried out when the dorsal wound was touched, or when the left foot was moved. The resident cried out, "Stop," and "Don't do that." The resident also pulled his/her left leg up toward him/her. Interview with the PTs at that time revealed the resident normally expressed that much pain with wound care. The PTs stated they did not call to have nursing pre-medicate the resident prior to treatment, and were unsure if the resident had received any pain medication that morning. Review of the note written by PT #2 following the treatment showed the resident complained of pain with treatment to the dorsal foot wound. Interview with licensed practical nurse (LPN) #3 at 10:30 AM revealed the resident did not receive a pain medication	F 282	discontinued and/or rescheduled to ensure unnecessary pain is not experienced. ◦ Nurses will be instructed to review the patient's care plan prior to treatment to ensure that treatment procedures are followed. ◦ The DON will monitor pain during treatment by reviewing charting of treatments to ensure patients are not experiencing unnecessary pain during treatment and by observing treatments on a monthly basis. Findings of the DON will be reported to the QAA committee. 2. ◦ Nursing staff will be instructed on Resident #16's care plan and reason as to why ROM to all extremities is important for all residents. Restorative nursing will re-evaluate Resident #16 as to the proper restorative care he/she should receive as to prevent further decline. ◦ The Restorative nurse will review the restorative logs each week to ensure that range of motion (ROM) is being performed on patients requiring restorative care. The DON will review the restorative plan and log each quarter to monitor the effectiveness of these procedures. The DON will report results to the QAA committee each quarter.	

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F 282	Continued From page 8	F 282		

prior to the physical therapy wound treatment. The LPN stated if PT called ahead and said when they were coming, they would pre-medicate residents.

b. Review of a 6/3/06 nursing note showed the resident complained of pain when touching the leg and foot. During an interview on 6/13/06 at 10:30 AM, LPN #3 stated nursing staff did not always pre-medicate the resident when they provided the wound treatment. A comparison of the medication administration record (MAR) and the treatment record for May and June 2006 showed the resident received wound care on the following dates, but did not receive any pain medication: 5/1/06, 5/7/06, 5/19/06, 5/22/06, 5/25/06, 6/5/06, 6/7/06, 6/12/06.

2. Review of the 6/29/06 annual MDS assessment for resident #16 revealed s/he had no functional limitation in either arm or hand. Review of the 3/28/06 quarterly and the 4/6/06 significant change MDS assessments revealed the resident had limited range of motion (ROM) in both arms and hands with partial loss of function. Review of the 4/13/06 care plan revealed the resident was to receive ROM to all extremities every shift. Review of the restorative care flow record for 5/06 revealed the resident received passive range of motion (PROM) to both lower extremities but not to either upper extremity. Interview with certified nurse aide (CNA) #13 on 6/15/06 at 10:15 AM revealed sometimes the resident received PROM and sometimes s/he did not.

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F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure adequate pain relief and failed to position a resident to facilitate the resident's ability to eat for one of nine sample residents (#2). The facility's failure to pre-medicate the resident prior to wound care resulted in pain which was avoidable. The findings were: PAIN 1. Review of the 4/27/06 significant change Minimum Data Set (MDS) assessment showed resident #2 had pain on a daily that was excruciating at times. Review of the 4/27/06 Resident Assessment Protocol (RAP) narrative for pressure ulcers showed the resident had two stage 4 ulcers to the left foot. Review of physician's orders showed the resident had the following pain medication ordered on a prn (as needed) basis: MS Contin 15 milligrams (mg) twice per day as needed, and Hydrocodone BIT/APAP 7./500 one to two tabs as needed every four to six hours. Review of physical therapy notes dated 2/16/06 and 2/22/06 showed the resident expressed pain with the wound to the left dorsal foot. Review of the 5/9/06 physical	F 309	PAIN 1. ◦ Nursing staff will be instructed on Resident #2's care plan and resident is to be administered pain medication 30 minutes prior to dressing changes. When P.T. is scheduled to change dressing, he/she will be instructed to call nursing staff to notify them of the time he/she will be performing the dressing change so licensed nursing staff will then medicate Resident #2 30 minutes prior to the scheduled dressing change. The dressing change/treatment is not to occur unless the patient has been medicated. Persons providing treatment will be instructed to confirm the patient is medicated prior to starting treatment. If during the dressing change, Resident #2 experiences pain, licensed nursing staff and/or P.T. is to stop the dressing change. The resident will then be medicated with a stronger medication, (MS Contin), and an attempt to change the dressing 30 minutes later can be attempted. ◦ The DON and ADON will review the Pain Assessment Policy with licensed nursing staff to ensure all patients are observed for unnecessary pain. The DON will review patient pain assessments each quarter to monitor the level of pain patients are experiencing and will observe treatments on a monthly basis to ensure unnecessary	7/15/06

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F 309	Continued From page 10 therapy plan of progress showed the dorsal wound was 1.2 centimeters (cm) in circumference and was painful. Review of the 4/10/06 pain assessment showed the resident had pain, including at the wound on the dorsal left foot. The assessment showed medication was usually effective. Review of weekly pain notes dated 5/9/06 showed the resident had pain in the left foot, and pain medications were effective. Review of the care plan dated 5/10/06 showed the resident had pain resulting from impaired skin integrity. The care plan stated "Administer analgesics 30 minutes before dressing change to foot." The following concerns were noted: a. Observation on 6/13/06 at 9:35 AM showed physical therapists (PTs) #1 and #2 provided wound care to the left heel and left dorsal foot. The dorsal wound on the foot was approximately 1 cm round. PT #1 stated she could not stage the wound because there was collagen present, and she was not sure what was underneath. PT #1 did sharp debridement of the dorsal wound, and put a new dressing on it. During the wound care, the resident cried out when the dorsal wound was touched, or when the left foot was moved. The resident cried out, "Stop," and "Don't do that." The resident also pulled his/her left leg up toward him/her. Interview with the PTs at that time revealed the resident normally expressed that much pain with wound care. The PTs stated they did not call to have nursing pre-medicate the resident prior to treatment, and were unsure if the resident had received any pain medication that morning. Review of the note written by PT #2 following the treatment showed the resident complained of pain with treatment to the dorsal foot wound. Interview with licensed practical nurse (LPN) #3 at 10:30 AM revealed the resident	F 309	pain is not experienced during treatment.	

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F 309	Continued From page 11 did not receive a pain medication prior to the physical therapy wound treatment. The LPN stated if PT called ahead and said when they were coming, they would pre-medicate residents. b. Review of a 6/3/06 nursing note showed the resident complained of pain when touching the leg and foot. During an interview on 6/13/06 at 10:30 AM, LPN #3 stated nursing staff did not always pre-medicate the resident when they provided the wound treatment. A comparison of the medication administration record (MAR) and the treatment record for May and June 2006 showed the resident received wound care on the following dates, but did not receive any pain medication: 5/1/06, 5/7/06, 5/19/06, 5/22/06, 5/25/06, 6/5/06, 6/7/06, 6/12/06. 2. Review of the facility's "Pain Assessment Policy" (number 1012, revised 5/05) showed "...residents with pain are identified and have interventions to relieve the pain so they can have enhanced quality of life...". POSITIONING 1. Observation during the evening meal on 6/12/06 from 6:20 PM until 7:05 PM revealed resident #2 was seated in a geriatric chair (wheeled recliner), with his/her legs elevated. The resident was positioned at a round table with his/her left side to the table. The resident was observed to eat with the right hand. The resident was observed twisting his/her back and reaching over his/her body with the right hand in order to reach the plate. The resident occasionally spilled food, and left food at the top of the plate. At 6:53 PM, the resident was trying to put the glass of	F 309	POSITIONING 2. ◦ All nursing staff will be instructed on proper positioning of Resident #2 and all residents in a geri chair for each meal. All nursing staff will be instructed on positioning of Resident#2 and all residents in order to reduce the chance of spillage, including proper placement of cups, utensils and plates.	

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F 309	Continued From page 12 milk down past the plate, but was unable to do so, and so he/she spilled the glass of milk on the table. During the meal, certified nurse aide (CNA) #24 was seated across from the resident, and did not re-position the resident in order to facilitate dining. 2. During an interview on 6/15/06 at 8 AM, the assistant director of nursing (ADON) stated it was the responsibility of the charge nurse to assure residents were positioned correctly at meals.	F 309	◦ All staff will be instructed on the need to clean all spills discreetly and in a timely fashion. ◦ The DON and charge nurses will be responsible for monitoring for proper positioning of residents and placement of dishes and utensils at each meal. The DON will monitor at random and will report any findings at the quarterly QAA meeting.	
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 interview, and review of facility policies and procedures, the facility failed to ensure staff provided the necessary care to maintain good personal hygiene for one (#29) of four sample residents who were incontinent of urine. The findings were: 1. Observation on 6/13/06 at 11 AM revealed the incontinence brief of resident #29 was saturated with urine. Continued observation revealed certified nurse aide (CNA) #13 provided perineal care but did not cleanse the anterior perineal area or upper thighs which were in contact with the urine. Review of the facility's policy on perineal	F 312	◦ All CNAs will be inserviced on how to perform appropriate perineal care on resident #29 and all other residents in this facility that are unable to perform this function by themselves. The CNAs will receive this facility's procedure on Perineal Care and it will be reviewed with them by the Infection Control Coordinator. The rationale for appropriate perineal care will be explained to the CNAs. ◦ The Director of Nursing and the Infection Control Coordinator will randomly monitor the CNAs on their appropriateness in following this facility's procedure on "Perineal Care". The CNAs will be corrected immediately and corrective action will be taken. The CNA will be monitored until perineal care is given correctly.	7/5/06

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F 312	Continued From page 13 care dated 1/05 revealed the following instructions: "10. First washcloth: Clean abdomen, both hips, and pubic area. 11. Second washcloth: Clean inner thighs. 12. Third washcloth: Cleaning the genital area." Interview with the infection control coordinator on 6/15/06 at 8 AM confirmed the anterior perineal area should have been cleansed.	F 312	This monitoring will occur randomly on an on going basis and will be used in the quality assurance process according to this facility's quality assurance program.	
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure one (#29) of four sample residents who were incontinent of urine was toileted as determined necessary by the treatment team to keep the resident clean and dry. In addition, the facility failed to ensure there was medical necessity for a catheter for one (#8) of seven residents with catheters. The findings were: INCONTINENCE Review of the nursing progress notes and the	F 315	INCONTINENCE ◦ On July 10, 2006, Resident #29 will be placed on incontinence monitoring using a bladder scanner every hour for a 72 hour period to establish a toileting routine to maintain continence. ◦ Incontinent residents will be evaluated for a toileting plan based on the degree of their incontinence. The DON will monitor patients with a toileting plan by observation of one patient each week at random through an entire shift. ◦ Nursing staff will be instructed on the risks of not adhering to patient toileting plans. Nursing staff found not adhering to toileting plans will be instructed on the necessity and put under additional supervision to ensure the toileting plan is understood. ◦ The DON will report issues regarding the toileting plan procedure to the QAA committee.	7/15/06

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F 315	Continued From page 14 12/21/05 Resident Assessment Protocol Rationale report for resident #29 revealed s/he was incontinent of urine. Observation on 6/13/06 from 7:20 AM until 11 AM (3 hours and 40 minutes) revealed the resident was not toileted or checked for incontinence. Observation on 6/13/06 at 11 AM revealed the resident's incontinence brief was saturated with urine. Interview with certified nurse aide #13, also at that time, revealed the resident required toileting before and after meals and at bedtime. Interview with CNA #15 on 6/13/06 at 11:23 AM revealed the resident required toileting before and after meals and at bedtime. CATHETER Review of the 4/26/06 quarterly and 11/4/05 annual Minimum Data Set (MDS) assessments revealed supplemental resident #8 had an indwelling urinary catheter. Review of the 11/4/05 Resident Assessment Protocol (RAP) summary for incontinence/catheter revealed the resident had the catheter due to urinary incontinence related to a diagnosis of dementia. The summary documented the resident had recurrent urinary tract infections. Review of physician orders showed an order for the catheter on 4/30/01. Review of the 1/11/06 bowel and bladder retraining assessment revealed the resident had a catheter "...for urinary elimination." There lacked documentation of a medical reason for the catheter. During an interview on 6/15/06 at 8 AM, the assistant director of nursing stated the catheter was used because the family wanted it.	F 315	CATHETER ◦ On 07/10/06, the ADON spoke with Resident #8's physician and was able to receive a diagnosis of urinary retention. ◦ Bi-monthly, the DON, ADON and MDS coordinator will review resident medical records for patients with an indwelling catheter to ensure there is a proper diagnosis and determine if the resident is a candidate to remove the indwelling catheter. ◦ The DON and ADON will instruct resident families on the risk of having indwelling catheters upon admission and at quarterly care plan meetings. The DON will monitor for appropriate placement of catheters at quarterly patient care plan meetings. Results of monitoring will be shared with the QAA Committee.	7/15/06

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F 318 SS=G	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide restorative exercises to prevent further decline in range of motion for two (#2, #16) of four sample residents who required restorative services. One resident (#16) did not receive planned services and had a decline in range of motion. The findings were: 1. Review of the 6/29/05 annual Minimum Data Set (MDS) assessment for resident #16 revealed s/he had no functional limitation in either arm or hand. Review of the 3/28/06 quarterly and the 4/6/06 significant change MDS assessments revealed the resident had limited range of motion (ROM) in both arms and hands with partial loss of function; a decline over the past two and one-half months. Review of the 4/13/06 care plan revealed the resident was to receive ROM to all extremities every shift. Review of the restorative care flow record for 5/06 revealed the resident received passive range of motion (PROM) to both lower extremities but not to either upper extremity. Interview with certified nurse aide (CNA) #13 on 6/15/06 at 10:15 AM revealed sometimes the resident received PROM and sometimes s/he did not. Interview with licensed practical nurse #1 on	F 318	◦ The DON will instruct the CNAs on the importance of performing ROM exercises, AROM/PROM, to prevent a decline in ROM, and contractures. ◦CNAs were also instructed the RNA is not the only staff that can perform ROM exercises. ROM can be provided in different ways such as combing his/her hair, brushing teeth, dressing, etc for those residents that are capable of performing their own personal care. Those residents unable to perform their own personal care, PROM can be performed while getting him/her dressed. C.N.A.'s were instructed to document ROM when performed or notify the RNA, so that she can document the ROM as completed. ◦ The DON and ADON will in-service nursing staff on the ROM policy which states, "All residents confined to a chair or bed are to receive ROM to all extremities unless otherwise specified by the physician. ◦ The Restorative nurse will review the restorative logs each week to ensure that range of motion (ROM) is being performed on patients requiring restorative care. The DON will review the restorative plan and log each quarter to monitor the effectiveness of these procedures. The DON will report results to the QAA committee each quarter.	7/15/06

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F 318	Continued From page 16 6/15/06 at 8:05 AM confirmed the resident had a decline in ROM in March 2006. 2. Review of the 4/27/06 significant change Minimum Data Set (MDS) assessment showed resident #2 had range of motion limitations to both arms, both legs, and both feet. Review of the 4/10/06 restorative nursing services patient plan (for the period 4/06 through 9/06) revealed the resident was supposed to receive exercises/range of motion to the upper and lower extremities "daily." However, review of the May 2006 restorative flow record showed the resident did not receive services on 14 of the 31 days. Review of the June 2006 flow record through June 12th showed the resident did not receive services on 3 of the 12 days. During an interview on 6/15/06 at 8:55 AM, restorative nurse aide (RNA) #16 stated daily meant seven days a week. In addition, the RNA stated if services were not provided, it was probably on days she was not working. The RNA further stated she was not sure why services would not be provided, because the certified nurse aides (CNAs) could provide the services as well.	F 318		
F 323 SS=D	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, medical record review, and resident and staff interview, the facility failed	F 323	◦ Facility staff will perform room to room checks for items that are labeled with any cautionary statements, in addition to any items that lack any kind of labeling. These items will be removed and placed into a labeled bag until the nurse on duty is able to determine if the item is safe. The	7/15/06

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F 323	Continued From page 17 to ensure various areas of the environment were free of accident hazards. The findings were: 1. Observations on 6/13/06 at 7:25 AM and 6/15/06 at 8:50 AM revealed a jar of "Vicks VapoRub" and a bottle of fingernail polish remover on the bed-side table of resident #9. Review of the medical record showed there was no evidence of any safety assessment done for the use of these items and no evidence of a physician's order for the vapor rub. Interview with the resident on 6/15/06 at 8:50 AM confirmed s/he used the vapor rub by putting it in his/her nostrils when needed, and stated a family member supplied it. According to the label on the "Vicks VapoRub", it is for "external use only; avoid contact with eyes" and "Do not use: in nostrils". Interview with the assistant director of nursing (ADON) on 6/14/06 at 2 PM revealed she was unaware the resident used the vapor rub, and confirmed there was no assessment completed for safety as far as she knew, and no physician's order. 2. Observation on 6/12/06 at 5:35 PM and again on 6/13/06 at 7 AM revealed resident #13 had a jar of Vicks Vapor rub and a bottle of Tums Ultra on the bedside table. Medical record review revealed no assessment for self administration of medications, nor a physician's order to leave medications at the bedside. During an interview on 6/14/06 at 11:25 AM, the assistant director or nursing (ADON) stated there was not an assessment for self administration of medications, nor was there a physician's order which stated medications could be left at the bedside. The ADON stated normally there would be a physician's order.	F 323	beauty shop door will be posted to keep the door closed when staff is not in attendance. ◦ Resident #23 will have a wheelchair positioning and safety evaluation performed by the Occupational Therapist to determine if the seat belt on her chair is necessary or appropriate. ◦ Weekly walk thrus will be completed by nursing staff to ensure items that could be hazardous are immediately identified and that the beauty shop door remains closed. All staff will be instructed to remove items from resident access in any room of the facility if the items are labeled with cautionary statements or are not properly labeled. All staff will be instructed to keep the beauty shop door closed unless a staff member is present. Nursing staff will be instructed on the proper use of seat belts on wheelchairs. ◦ An assessment will be completed for any resident who has physicians orders for items at the bedside to ensure the residents is capable of safely handling the items. All residents with seat belts on their wheelchairs will be assessed by the Occupational Therapist to determine the necessity and safety of the belt. ◦ Residents will be care planned to self administer bedside items when deemed appropriate by facility assessment and physician order.	

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F 323	Continued From page 18 3. Observation on 6/14/06 at 9:20 AM revealed the door to the beauty shop was open, and staff were not present. There was a plugged in curling iron on top of the counter upon entering the room. The curling iron was hot to the touch. 4. Observation on 6/13/06 at 1 PM of the sun room/activity room revealed the room did not have a door, and drawers were not locked. Observation in one of the drawers revealed two bottles of fragrance oils which contained the warning "...caution...not for consumption..avoid contact with eyes, skin...", There was no staff present in the room at the time of the observation. 5. Review of the 12/21/05 annual and the 3/21/06 quarterly Minimum Data Set (MDS) assessments for resident #29 revealed s/he had moderate cognitive impairment. Further review of these documents revealed the resident had wandering behaviors daily. Observation on 6/13/06 at 9:10 AM revealed the resident wandered into another resident's room. Review of the 1/26/06 nursing progress notes revealed the resident was fond in another resident's room. The following concern was identified: a. Observation of the room of the resident's room on 6/13/06 at 4 PM revealed the following items located in a container on the nightstand: Three bottles of nonalcoholic mouthwash with the warning label "Keep out of reach of children", and one bottle of Deoderant with the warning "Keep out of reach of children", 6. Observation of the room of resident #16 on 6/13/06 at 10:10 AM revealed the following concerns:	F 323	◦ Residents who self administer items will have their assessments reviewed by the Director of Nursing quarterly to ensure that the capability continues. Patients using seat belts on their wheelchairs will have their care plans reviewed quarterly by the Director of Nursing and compared with the Occupational Therapist's assessment to ensure that seat belts being used are necessary and safe. ◦ Findings of the Director of Nursing will be reported to the Administrator and reported to the Quality Assessment and Assurance Committee at the quarterly meeting.	

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F 323	Continued From page 19 a. On the nightstand was one bottle of periwash cleanser with the cautionary statement "Keep out of eyes. In case of accidental eye contact DO NOT RUB EYES. Flush eyes thoroughly with water. If swallowed consult a physician or poison control center. Keep out of reach of children. For external use only." b. In the partially open drawer of the nightstand was one jar of "sween cream" with the cautionary statement "For external use only." and one bottle of wound wash saline with the warning "For external use only. Keep out of reach of children." 7. Review of the medical record for resident #23 showed a consent form for a self-releasing seat belt "for sense of security" dated 1/15/03. Review of the 5/11/06 care plan showed the resident used a seat belt in the wheelchair. Observation of the resident on 6/12/06 at 4:10 PM, on 6/13/06 at 6:55 AM and 12:55 PM, and on 6/14/06 at 2 PM revealed the resident was seated in the wheelchair. The resident had a seat belt, but the seat belt was not secure at the level of the resident's hips. The seat belt was loose, and was resting on the middle of the resident's thighs. Review of the medical record revealed no assessment to determine the safety of the seat belt, including the possibility of the resident slipping down in the wheelchair. During an interview on 6/15/06 at 8 AM, the ADON stated there was not an assessment for the correct fit of the seat belt, nor an assessment for safety.	F 323		

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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, staff interview, and review of in-service education records, the facility failed to assure appropriate footwear was worn during transfers for one of five sample residents (#13) with a history of falls. The findings were: Review of the 6/8/06 significant change Minimum Data Set (MDS) assessment showed resident #13 had fallen in the past 31-180 days. Review of a 3/4/06 nursing note showed the resident was being assisted by two staff, the gait belt slipped and the resident slid to the floor. Review of a 5/4/06 nursing note showed the resident was found on the floor. Review of the 3/2/06 fall risk assessment revealed the resident was at high risk for falls. Review of the 5/11/06 care plan for falls showed appropriate footwear during transfers was not addressed. The following concerns were noted: a. On 6/12/06 at 5:35 PM, certified nurse aides (CNAs) #15 and #27 transferred the resident from the recliner to the wheelchair in the resident's room, which had tile flooring. The CNAs held the resident under his/her arms (one on each side of the resident) and did not use a gait belt. During the transfer, the resident's feet slipped out from under him/her, and the CNA's were holding the resident up by his/her arms. When the resident was put in the wheelchair, it was observed the resident had socks on his/her	F 324	◦ The nursing staff will be instructed on proper lifting and transferring procedures. They will be reminded to check for appropriate footwear and to use a gait belt whenever transferring a patient. The P.T.'s will be instructed to follow facility procedures when lifting and transferring patients, including checking for appropriate footwear and the use of a gait belt. ◦ The DON will monitor lifts and transfers at random to ensure that caregivers are following proper procedures. Findings of random observation will be used in the QAA process in accordance with this facilities policy.	7/15/06

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F 324	Continued From page 21 feet. At that time, CNA #27 looked in the resident's drawers, and stated the resident was out of "sticky socks" (non-skid socks). b. On 6/13/06 at 7 AM, CNA #27 transferred the resident from bed to the wheelchair using a gait belt. The resident had on socks, and during the transfer, the resident's feet slid on the floor, but the CNA was able to get the resident into the wheelchair. c. On 6/13/06 at 9:06 AM, physical therapist #2 transferred the resident from the recliner to the wheelchair without a gait belt. The resident wore socks on his/her feet. d. On 6/15/06 at 8 AM, the assistant director of nursing stated the resident probably just had socks on his/her feet during previous falls. Review of in-service education provided to staff on 6/7/06 revealed "...Assess situation first...Pt's footwear appropriate?..." Review of the brochure "Lifting & Moving Patients Safely" attached to the in-service education materials revealed "...Does he or she have proper footwear?"	F 324		
F 370 SS=E	483.35(i)(1) SANITARY CONDITIONS - FOOD PROCUREMENT The facility must procure food from sources approved or considered satisfactory by Federal, State, or local authorities. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure all food items were from	F 370	◦ Improperly marked packages that are in the freezer will be removed and disposed of. ◦ The Dietary Manager will monitor the food in the facility's possession by performing bi-weekly observations of food in storage to ensure it is properly marked and inspected.	6/15/06

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F 370	Continued From page 22 an approved source. The findings were: Observation on 6/12/06 at 4:15 PM revealed several boxes in the outside walk-in freezer contained numerous packages wrapped in white paper labeled "lamb". There were no markings to indicate if it was inspected or where the lamb was packaged. Interview with the dietary manager on 6/14/06 at 8:55 AM revealed the lamb was donated from a person in the community, and it was not from an approved source. She stated the quantity was two full butchered lambs and was donated to the facility in December 2005. She further stated she had planned to give it away to staff. According to Food Code 2005, U.S. Public Health Service, 3-201.11 Compliance with Food Law. (A) FOOD shall be obtained from sources that comply with LAW. (B) FOOD prepared in a private home may not be used or offered for human consumption in a FOOD ESTABLISHMENT. (C) PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under §3-202.17 and 3-202.18.	F 370	◦ The Dietary Manager will report any findings at the QAA meeting each quarter.	

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F 371 SS=F	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, review of the cleaning schedule and review of facility policy and procedure, the facility failed to ensure proper techniques to prevent possible contamination during food storage and preparation. The findings were: 1. The following concerns were noted with food storage ; a. Observation on 6/12/06 at 4:15 PM revealed approximately 20 cases of frozen foods were stored on flat plastic racks placed directly on the floor of the walk-in freezer. b. Observation on 6/12/06 at 4:15 PM, and 6/13/06 at 6:55 AM showed raw meat in the walk-in refrigerator labeled "stew meat" and "pork roast" thawing on a shelf directly above a pan labeled "manicotti" and a container labeled "french onion soup". c. Interview with the certified dietary manager (CDM) on 6/14/06 at 8:55 AM revealed she knew food should not be stored on the floor, and to prevent possible contamination, raw meats should be stored on the bottom shelf. According to Food Code 2005, U.S. Public Health Service 3-305.11; Food Storage. FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other	F 371	1.a. ◦ Cases of frozen foods placed on the plastic racks on the floor will be moved to 6 inches above the floor. b./c. ◦ All dietary staff will be instructed regarding proper food storage and thawing of foods. ◦ New containers for food thawing have been obtained to eliminate the need for the use of larger containers, which take up more space. Existing "thawing signs" will be replaced with more food specific signs. ◦ The Dietary Manager will randomly monitor food storage areas for proper food storage.	7/15/06

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F 371	Continued From page 24 contamination; and (3) At least 15 cm (6 inches) above the floor. According to Food Code 2005, U.S. Public Health Service 3-302.11 Packaged and Unpackaged Food-Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD... (b) Cooked READY-TO-EAT FOOD; 2. The following concerns were noted with the cleanliness of the dish room and food preparation area: a. Observation on 6/14/06 at 4:15 PM revealed a black build-up approximately two feet long by one and one-half inch high on the back splash of the sink near the sprayer in the dish room. Interview with the CDM revealed this was mold, and it had been a problem for the past year. She further stated she "tries to clean it daily with bleach". b. Observation on 6/12/06 at 4:15 PM showed the hoods above the range had a build up of dust and grease. Review of the facility policy titled "cleaning the dietary department" dated 5/05, showed the hoods were to be cleaned weekly. Review of the cleaning schedule showed the last time this was done was 5/24/06 (3 weeks prior). c. Observation on 6/14/06 at 8:55 AM revealed a light above a food preparation table with a plastic cover that was cracked and hanging down. Additionally, next to this light there was an air vent which was dusty and falling away from the ceiling. Interview with the CDM confirmed the cleaning was not completed as frequently as	F 371	2.a. ◦ The caulking will be removed and the mold cleaned off with a heavy-duty cleaner, designed specifically for mold. The wall will be allowed to dry then Kilz (a mold prevention latex product) will be applied and 100% silicone caulking will be used to reseal the area. ◦ Maintenance will monitor and document signs of mold each month. Maintenance will research and find a product that can be sprayed on the wall each week to prevent the growth of mold until the new kitchen can be constructed. b. ◦ The inside hood will be completely cleaned and will continue to be cleaned and documented in the "Cleaning Task Book" twice each month. ◦ The Dietary Manager will monitor the "Cleaning Task Book" and the condition of the hood unit to ensure the area is sanitary for food preparation. c. ◦ Maintenance will replace 29 light covers and tighten the vent covers on the ceiling and clean them.	

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F 371	Continued From page 25 scheduled and it needed to be done. She further agreed the light and vent above the preparation table should be fixed. According to Food Code 2005, U.S. Public Health Service 4-602.13: Nonfood-Contact Surfaces. Non FOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. According to Food Code 2005, U.S. Public Health Service 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306.	F 371	◦ Maintenance will monitor for broken light covers and loose vent covers on weekly walk thrus to ensure sanitary conditions are not compromised. ◦ The Dietary Manager and Maintenance Director will report findings of monitoring to the QAA committee quarterly.	
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies and procedures, the facility failed to ensure staff followed handwashing protocols during one of two meal observations. The findings were: Observation in the dining room on 6/12/06 at 6:32 PM revealed resident #6 coughed and spewed food on himself/herself. Observation revealed certified nurse aide (CNA) #18 wiped the food and spittal from the resident's mouth and then,	F 444	◦ The Director of Nursing, the Infection Control Coordinator, and the Charge Nurses will observe and monitor the nurse's aides as they perform hand hygiene before and after giving direct care to residents #6 at meals. The nursing staff may use soap and water and/or an alcohol based hand sanitizer to perform hand hygiene. ◦ All CNAs will be inserviced on appropriate hand hygiene according to the Center's procedure. This inservice will be given by the Infection Control Coordinator. The CNAs will be given the written procedure on how to perform appropriate hand hygiene. ◦ Thorough monitoring of the CNAs by the DON and Infection Control Coordinator, the appropriateness of hand hygiene will be indentified and inserviced immediately. Corrective action will be taken when hand hygiene is not performed correctly or not performed between each resident during meals and at all other times when direct care is given.	7/15/06

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F 444	Continued From page 26 without washing or sanitizing her hands, assisted another resident seated at the same table with eating. Interview with the infection control coordinator on 6/15/06 at 8:50 AM confirmed the CNA should have washed or sanitized her hands prior to assisting another resident with eating. Review of facility policies and procedures revealed there was no policy on handwashing; only instructions on how to perform handwashing.	F 444	◦ A Hand Hygiene policy will be developed and put into place that will accompany the "Handwashing Procedure" that is already in place. ◦ Monitoring will be at random as an on going process and used in the quality assurance process according to this facility's quality assurance program.	
F 467 SS=F	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an operational ventilation system throughout the building and resident rooms. The census was 34. The findings were: Observation on 6/13/06 at 1 PM of the bathrooms in resident rooms 1 and 5 revealed no sound coming from the overhead vent. Observation in both bathrooms in the lobby revealed no sound from the overhead vents. When tissue paper when placed on the vent, the tissue paper did not cling to the vent. During a tour on 6/14/06 at 2:15 PM, the maintenance director stated it appeared the ventilation system was not working in the main bath, and some of the resident room bathrooms. The maintenance director stated the facility had a central evacuation system, so all of	F 467	◦ The ventilation system motors will be replaced and vents will be checked to be sure they are in working order. ◦ All staff will be instructed to report excessive lingering of unwanted odors by completing a work order for the Maintenance Director. ◦ The Maintenance Director will perform monthly checks to monitor the ventilation system and ensure that the system is working consistently and will respond immediately to work orders produced with odor complaints. ◦ The Maintenance Director will report complaints to the Administrator and will share his findings with the Quality Assessment and Assurance Committee in the quarterly meetings.	7/5/06

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F 467	Continued From page 27 the rooms were on the same ventilation system. He stated he would have to climb in the attic to see if the ventilation system was working. During an interview on 6/15/06 at 10:55 AM, the administrator stated the maintenance director had been in the attic and on the roof. The ventilation system was not working, and they were going to call in a contractor.	F 467		
F 492 SS=F	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure certified nurse aides (CNAs) performed tasks for which they were qualified and which were within their scope of practice. Furthermore, the facility failed to assure licensed nurses delegated tasks appropriately to CNAs. The findings were: Interview with licensed practical nurse (LPN) #2 on 6/13/06 at 1:30 PM and with the assistant director of nursing on 6/15/06 at 8:50 AM revealed CNAs performed the weekly skin assessments while bathing or showering residents and had the nurses sign off on the skin assessment form. They further stated the nurse would sometimes also perform a skin	F 492	◦ Licensed nursing staff will be instructed to perform the weekly skin assessments as per physician orders. C.N.A.'s will continue to check patient skin and address any concerns observed to the licensed nurses. ◦ Tasks delegated to C.N.A.'s will be reviewed for appropriate scope prior to implementation by the DON. The Administrator will monitor policies for proper scope of practice during annual policy reviews to ensure professional standards are being met. and will address in the QAA process.	7/15/06

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F 492	Continued From page 28 assessment if the CNA reported a concern but nurses did not routinely perform the weekly skin assessments as ordered by physicians. According to the July 2005 Nursing Practice Act and Administrative Rules and Regulations November 2003, performing a skin assessment was not within the scope of practice for CNAs. Further review of the July 2005 Nursing Practice Act and Administrative Rules and Regulations November 2003 revealed " 'delegation' decisions must be made by the licensed nurse on the basis of the skill levels of the care givers." Further review showed the delegating nurse must delegate only those tasks which are within the CNAs "area of responsibility and scope of practice."	F 492		
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 staff interview, and medical record review, the facility failed to ensure laboratory tests were completed as ordered for one (#6) of nine sample residents. The findings were: Review of the 12/30/05 physician's orders for resident #57 revealed an order for a recheck urinalysis and culture in one week because of a urinary tract infection. Review of the entire medical record revealed there was no report of a	F 502	◦ The lost sample/results from 12/30/05 cannot be obtained. ◦ Licensed staff and Medical Records personnel under the direction of the DON will be instituting the following check and balance system to ensure all ordered laboratory work is received in a timely manner: a copy of the lab requisition will be placed in a notebook by the licensed staff. The Medical Records personnel will check the notebook to be sure those results have been received and placed into the medical record. If the results are not received within 3 business days, the Medical Records personnel will contact	7/15/06

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F 502	Continued From page 29 urinalysis or culture during the first week of January 2006 (one week after the 12/30/05 order for a recheck). Interview with the assistant director of nursing on 6/15/06 at 8:50 AM revealed the urine sample had been sent to the laboratory but the sample was lost and subsequently the urinalysis and culture were not performed.	F 502	the lab to ensure that samples were received. ◦ Licensed staff and Medical Records personnel will receive instruction on this new system. ◦ The DON will monitor this new system and report to the QAA committee the results and make changes as deemed necessary with given results to prevent lost or missing lab results.	
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 staff interview and medical record review, the facility failed to ensure laboratory results were in the medical record for one (#16) of nine sample residents. The findings were: Review of the 1/24/06 physician's orders for resident #16 revealed total protein, albumin, and pre-albumin tests were ordered. Review of the entire medical record revealed the results of these tests were not in the medical record. Interview with the assistant director of nursing on 6/15/06 at 11 AM revealed the tests were completed but the results were not in the facility.	F 507	◦ A request will be made for a copy of lab results for the tests ordered for Resident #16 on 1/24/06, the results will be placed in the medical record. ◦ Licensed staff and Medical Records personnel under the direction of the DON will be instituting the following check and balance system to ensure all ordered laboratory work is received in a timely manner: a copy of the lab requisition will be placed in a notebook by the licensed staff. The Medical Records personnel will check the notebook to be sure those results have been received and placed into the medical record. If the results are not received within 3 business days, the Medical Records personnel will contact the lab to ensure that samples were received. ◦ Licensed staff and Medical Records personnel will receive instruction on this new system. ◦ The DON will monitor this new system and report to the QAA committee the results and make changes as deemed necessary with given results to prevent lost or missing lab results.	7/15/06

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	535017	A. BUILDING _____ B. WING _____	06/15/2006

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 513 SS=D	483.75(k)(2)(iv) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure radiology results were in the medical record for one (#29) of two sample residents. The findings were: Review of the 5/8/06 physician's orders for resident #29 revealed an order for an x-ray of the right knee because the resident had pain when s/he walked. Review of the entire medical record revealed the results of the x-ray was not in the medical record. Interview with the assistant director of nursing on 6/15/06 at 11 AM revealed the x-ray was taken on 5/8/06 but as of 6/15/06 (39 days) it had not been read by a radiologist so there were no results available.	F 513	◦ The Medical Record personnel will contact the physician to obtain a copy of the radiologists report from the x-ray taken on Resident #29 on 5/8/06. The report will be filed in the medical record. ◦The Medical Records personnel and the DON will develop an "X-ray / Diagnostic Test Requisition" form to be used and completed by the licensed nursing staff when an x-ray and/or diagnostic test is ordered. The form will include only necessary information to obtain the test results. The Medical Records personnel will then review the requisitions weekly to ensure that results have been obtained in a timely manner. The Medical Records personnel will document all attempts to obtain results and will report to the DON if results are not received after three failed attempts. ◦ The DON will monitor the Medical Records personnel to be sure the system is working properly and make changes to ensure the system is working for a minimum of 90 days. The DON will report to the QAA committee results of monitoring.	7/15/06

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F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure medical records were accurate for one (#16) of ten sample residents. The findings were: Review of the 4/06 signed physician's orders for resident #16 revealed two conflicting orders for repositioning the resident in regard to his/her pressure sore on the right hip. Review revealed one order instructed "Clock turning schedule 12-2:00 supine, 2:00-4:00 left side lying, 4:00-6:00 right side lying, 6:00-8:00 supine, 8:00-10:00 left side lying, 10:00-12:00 right side lying when in bed." The same monthly order sheet revealed an order that instructed "Pt. [patient/resident] needs to be kept off her rt.[right] hip ...." because there was a developing pressure sore. Review of the 5/06 and 6/06 treatment records revealed the resident was turned according to the instructions that included being placed on the right side. However, interview with certified nurse aide (CNA) #13 on 6/13/06 at 7:15	F 514	◦ The MDS Coordinator will review physician orders on Resident #16 for any duplicate orders or contradicting orders on a monthly basis. The MDS Coordinator will contact Resident #16's physician to see which order is to be followed. The MDS Coordinator will then discontinue the order the physician does not want to continue. ◦ The MDS Coordinator and DON will review physician orders bi-monthly to ensure that the orders do not contraindicate each other and will contact the physician to clarify the orders and ensure the information in the medical record is clear. ◦ The DON will monitor the effectiveness of this process by reviewing physician orders in patient charts once each quarter and reporting any findings to the Quality Assessment and Assurance Committee.	7/15/06

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F 514	Continued From page 32 AM revealed the resident was kept off his/her right side because of the pressure sore. Observation at this same time revealed a sign posted at the head of the resident's bed that instructed the resident should not be placed on his/her right side. Periodic observations from 8 AM through 6 PM on 6/13/06 and from 8:30 AM through 6 PM on 6/14/06 revealed the resident was not placed on his/her right side.	F 514		
F 516 SS=E	483.75(l)(3), 483.20(f)(5) CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safeguard medical records from unauthorized access in order to protect the confidentiality of residents. The findings were: Observation with the administrator on 6/15/06 at 9:05 AM revealed some resident medical records were stored in a building next to the facility (the	F 516	◦ The home health agency will surrender their key and access to the medical records room in the annex building. ◦ The medical records clerk will receive requests for records and will provide only those records appropriate for the requesting agent. In the event the medical records clerk is unavailable the Administrator will serve as relief access to medical records and will only release those medical records that are appropriate for the requesting individual. The medical records clerk and the Administrator will have signed confidentiality agreements on file. ◦ In this manner the facility will safeguard clinical record information against loss destruction, or unauthorized use. A record of information released from the records room in the annex building will be kept inside the room to	7/5/06

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F 516	Continued From page 33 "annex" building). The door was locked, and inside revealed medical records in boxes. The administrator stated the home health agency also had a key to access the room.	F 516	ensure records are released and returned accordingly. • All staff will be instructed on the new medical records procedures. This procedure will be reviewed in the Quality Assessment and Assurance Meeting by the Administrator.	