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

PRINTED: 03/29/2012
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
	535051	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse RN-Registered Nurse ADLs- Activities of Daily Living MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date. The facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary.	4-29-12
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164	**F164-Personal Privacy/Confidentiality of Records** Resident #25 has been discharged. The facility ensures that all residents receive privacy during personal care. Certified Nursing Assistants will be in serviced on the importance of providing privacy to residents during personal care.	4-29-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Walter Tovell, NHA — TITLE — (X6) DATE: April 4, 2012

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.

Accepted w/changes made via phone call on 4/16/12

with Walter, NHA; and Brenda, DON. DC: 4/29/12

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F 164	Continued From page 1 and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to provide privacy during personal care for 1 of 7 sample residents (#25). The findings were: Review of the medical record for resident #25 showed s/he had diagnoses to include diabetes and bilateral below the knee amputations. Observation on 3/13/12 at 7:34 AM showed the resident was uncovered in the room laying in bed with his/her night clothes pulled up to waist level. The bed covers were pulled back to the foot of the bed and a wash basin was sitting at the bedside. The resident's bed was located directly across from the room's entrance door. In addition, the privacy curtain in the room was not pulled and when staff or visitors entered the room, the resident was fully exposed. Interview with CNA #5 on 3/13/12 at 10 AM revealed she did not close the privacy curtain because the resident was the only person assigned to the room at that time. However, she acknowledged the resident would be exposed to anyone entering the room when the curtains were not pulled	F 164	To be completed by the DNS or designee. Five random observations of personal care will be completed each week to ensure resident privacy is being maintained during personal care x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	

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F 164	Continued From page 2 around the resident.	F 164		
F 170 SS=E	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure mail was delivered to residents on Saturdays. The findings were: Interview with seven residents during a group meeting on 3/13/12 at 1 PM revealed residents did not receive mail on Saturdays. Interview with the DON on 3/15/12 at 7:35 AM verified mail was not delivered to residents on Saturdays because no administrative staff was available to pick the mail up at the post office. The DON further said mail was delivered to the community on Saturdays, just not to the residents.	F 170	**F170-Right to send/receive unopened mail** Current facility residents are receiving mail on Saturdays. The facility ensures that all residents receive mail on Saturdays. The Administrator, Business Office Manager and Director of Activities will be in-serviced on the right for residents to receive mail on Saturdays. To be completed by the Administrator. An audit will be completed each week to insure that the facility has delivered mail to residents each Saturday x 90 days. To be completed by the Administrator or designee. Audit findings will be reviewed at the QA meeting.	4-29-12
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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	F 225	**F225-Nurse Aide Registry** C.N.A's #1, #2 and #3 have been verified through the Nurse Aide Abuse registry.	4-29-12

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F 225	Continued From page 3 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 by: Based on review of personnel files and staff interview, the facility failed to review the State nurse aide abuse registry before hiring 3 of 3 CNAs (#1, #2, #3). The findings were: Review of personnel records on 3/14/12 at 3:25 PM for CNAs #1, #2 and #3 failed to show evidence the State nurse aide abuse registry was checked for findings of abuse or neglect prior to	F 225	The facility ensures that all certified nursing assistants are verified through the Nurse Aide Abuse Registry prior to hire. The Director of Nursing and the Business Office Manager will be in-serviced on the importance of verifying all certified nursing assistants through the Nurse Aide Abuse registry prior to hire to ensure compliance with Wyoming law. To be completed by the Administrator/designee. A weekly audit will be completed on all certified nursing assistant employment applications to ensure they have been verified through the Nurse Aide Abuse registry prior. To be completed by DNS/designee. Audit findings will be reviewed at the QA meeting.	the newly developed P+P

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F 225	Continued From page 4 their hire dates. The business office manager confirmed in an interview on 3/14/12 at 4:01 PM she was unaware the nurse aide abuse registry was required to be reviewed prior to hiring CNAs.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of personnel files and facility policies and procedures, the facility failed to include in their policies and procedures the requirement for checking the State nurse aide abuse registry prior to hiring 3 of 3 CNAs (#1, #2, #3). The findings were: Review of the undated facility "Abuse Policy" revealed it was not developed to include the requirement for checking the nurse aide abuse registry prior to employment. Review of personnel records for CNAs #1, #2 and #3 failed to show evidence the State nurse aide abuse registry was checked for findings of abuse or neglect prior to their hire dates. The business office manager confirmed in an interview on 3/14/12 at 4:01 PM she was unaware of the requirement to check the abuse registry prior to hiring CNAs.	F 226	**F226-Facility Abuse Policy** The facility has a policy and procedure for verifying all certified nursing assistants through the Nurse Aide Abuse Registry prior to hire. developed The facility ~~ensures that~~ to hiring policies and procedures include the requirement for checking the Nurse Aide Abuse Registry prior to hiring any certified nursing assistants. The Director of Nursing and the Business Office Manager will be in-serviced on the importance of having a hiring policy that verifies all certified nursing assistants through the Nurse Aide Abuse Registry, prior to hire, to ensure compliance with State and Federal law. To be completed by the Administrator/designee. A weekly audit will be completed on all certified nursing assistant employment applications to ensure that the facility policy for verification through the Nurse Abuse Registry has taken place. To be completed by the DNS/designee. Audit findings will be reviewed at the CQI meeting.	4-29-12
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		4-29-12

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F 241	Continued From page 5 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 resident and staff interview, the facility failed to ensure dignity was maintained for 6 of 10 residents (#40, #43, #45, #46, #47, #48) who lived in the secure unit during 3 of 3 meal observations. In addition, the facility failed to interact with 1 of 12 sample residents (#42) in a respectful manner during a meal observation. Finally, the facility failed to ensure dignified personal hygiene during 3 of 3 random observations for residents #14 and #25. The findings were: In regard to meal observations: 1. Observation on 3/12/12 at 5:20 PM showed there was a bathroom located in one corner of the dining room in the secure unit. Observation showed six of the ten residents (#40, #43, #45, #46, #47, #48) who were eating their evening meal were seated such that they could see into the bathroom while eating. Observation showed the bathroom door was open during this time and residents could see nylon stockings and a pair of compression stockings drying on the towel rack and paper towels on the floor. A second meal observation on 3/13/12 at 7:54 AM showed the same situation. Finally, a third meal observation on 3/14/12 at 12:30 PM revealed the bathroom door was again open while residents were eating. Interview with the DON on 3/15/12 at 7:35 AM revealed the bathroom door should always remain closed, especially during meals.	F 241	**F241-Dignity and Respect** Residents #14, #40, #42, #43, #45, #46, #47, and #48 are stable. Resident #25 has been discharged. Being provided Care w/Dignity The facility ensures that all residents are treated with dignity and respect during dining and personal hygiene. The nursing staff will be in-serviced on the importance of ensuring that bathroom doors, which are in view of the dining room, will be closed during the meal to ensure that the resident's dignity is maintained. To be completed by the DNS/designee. The nursing staff will be in-serviced on the importance of obtaining appropriate utensils for the residents to eat with, thus ensuring that the resident's dignity is maintained. To be completed by the DNS /designee. The certified nursing assistants will be in-serviced on the proper method for determining correct brief sizing on residents thus ensuring resident dignity is maintained. To be completed by the DNS/designee. The C.N.A. staff will be in-serviced on the importance of ensuring that the	

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F 241	Continued From page 6 2. Observation on 3/13/12 at 7:58 AM showed resident #42 dropped his/her fork onto the floor during breakfast. Continued observation showed RN #2 said "I bet we don't have any extra [forks]." The RN looked and found there were no forks to replace the one dropped on the floor. She then said "Oh [s/he] has a spoon" and did not obtain a clean fork for the resident to finish eating breakfast. In regard to personal hygiene: 1. Review of the March 2012 nursing monthly summary sheet for resident #25 showed s/he was occasionally incontinent of urine, and received diuretic therapy (used to increase urine output). Observation on 3/13/12 at 9:40 AM, while interviewing the resident in his/her room, showed s/he was incontinent of urine. Although the resident wore an incontinence brief, the floor beneath the resident was pooled with urine. The resident stated s/he would need to call housekeeping to clean the floor. At 3/13/12 at 9:50 AM observation showed CNA #6 changed the resident's wet incontinence brief. The CNA had difficulty keeping the incontinence brief fastened, the fasteners would not hold the brief closed. Further, she stated larger incontinence briefs had been requested for the resident. Interview with CNA #6 on 3/14/12 at 4:10 PM revealed she had reported to a nurse the resident needed larger incontinence briefs approximately one month ago. During an interview with the DON on 3/15/12 at 12:50 PM she acknowledged she was aware the resident needed a larger size of incontinence briefs. She further said the proper size had not yet been determined so they had not	F 241	residents clothing is clean and free from food debris after each meal, thus ensuring the resident's dignity is maintained. To be completed by the DNS/designee. The nursing staff will be in-serviced on the importance of ensuring that the wheelchairs are clean prior to the residents utilizing them, thus ensuring the resident's dignity is maintained. To be completed by the DNS/designee. Five random audits will be completed each week to ensure that bathroom doors, which are in view of the dining room, are closed during meals x 90 days. To be completed by the DNS/designee. Five random audits will be completed each week to ensure that appropriate dining utensils are available to the nursing staff and are being utilized by the residents x 90 days. To be completed by the DNS/designee. Five random audits will be completed each week to ensure that the residents clothing is clean and free from food debris after meals x 90 days. To be completed by the DNS/designee.	

92

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F 241	Continued From page 7 been ordered. 2. Observation on 3/13/12 at 1 PM showed non-sample resident #14 arrived for the resident council meeting with crumbs and food debris on his/her shirt from lunch. In addition, the seat belt on the wheelchair was not clean. Observation on 3/15/12 at 9:20 AM revealed the resident again had on a soiled shirt and the seat belt in the wheelchair remained soiled. Interview with the resident at this time revealed s/he was bothered by the lack of a clean and neat appearance. The resident said appearance was important to him/her and s/he needed staff assistance with personal hygiene.	F 241	Five random audits of will be completed each week to ensure that resident wheelchairs are clean x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meetings.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to ensure the necessary accommodation was made in regard to providing an overhead trapeze for 1 non-sample resident (#14). The findings were: Observation on 3/13/12 at 1 PM showed there was no overhead trapeze on the bed of resident #14. Interview with the resident at the same time	F 246	**F246-Reasonable Accommodation** Resident # 14 has an overhead trapeze in place. The facility ensures that residents are provided with necessary accommodation regarding providing overhead trapezes or other adaptive equipment. The nursing staff will be in-serviced on ensuring that an assessment of mobility and/or functionality will be performed prior to the removal of an overhead trapeze. To be completed by the DNS/designee.	4-29-12

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F 246	Continued From page 8 revealed the trapeze on his/her bed was removed a few months ago. The resident said s/he thought it was removed because it was broken. The resident further said s/he really would like to have it back because it helped with bed mobility. Interview with the DON on 3/16/12 at 7:35 AM revealed, the trapeze was not broken but was removed because the CNA staff said the resident no longer used it. The overhead trapeze was then removed and placed on another resident's bed. The DON confirmed no assessment of the resident's mobility or functionality was performed prior to removing the trapeze from the bed to determine if the overhead trapeze was needed or not. It was just removed based on the CNAs statement.	F 246	A weekly audit will be completed on all residents with a request for the ~~removal of an overhead trapeze~~ adapted equipment, to ensure than an assessment of mobility and/or functionality has been performed x 90 days. To be completed by the DNS/ designee. Audit findings will be reviewed at the QA meeting.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	**F279 – Care Plan** Resident #11 has had a comprehensive care plan completed. The facility ensures that all residents have comprehensive care plans completed. The MDS coordinator will be in serviced on the importance of ensuring all residents have a comprehensive care plan in place. To be completed by the DNS/designee.	4-29-12

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F 279	Continued From page 9 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a comprehensive care plan was developed for 1 of 13 sample residents (#11). The findings were: Review of the medical record for resident #11 revealed s/he was admitted on 12/27/11 with multiple diagnoses including hemiparesis, dysphagia, hyperglycemia, hypertension, bilateral below knee amputation, osteoarthritis and a history of bladder cancer. An interdisciplinary care plan was dated the day of admission and consisted of a single sheet check-off form. A comprehensive care plan was not found in the record. A single sheet care plan conference summary was found in the record dated 2/23/12. However, none of the 16 care area categories identified as problems were addressed except activities. A line was drawn through the form stating "continue plan of care." Interview with the DON on 3/15/12 at 8:48 AM verified there was no other care planning documentation in the record.	F 279	Five resident care plans will be audited each week to ensure that they are comprehensive and complete x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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	F 280	**F280 – Participate in Care Planning** Resident #5, #39 and #44 have current and updated care plans. Residents #18 and #25 have been discharged.	4-29-12

4/11/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

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F 280	Continued From page 10 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 care plans were updated to reflect the current status for 5 of 13 sample residents (#5, #18, #25, #39, #44). The findings were: 1. Review of the quarterly MDS assessment dated 1/11/12 for resident #39 showed s/he required extensive assistance for bed mobility and for transfers. Review of the undated care plan revealed the following concerns: a. A transfer pole at the bedside was included as an intervention on the care plan. However, observation on 3/13/12 at 8:10 AM showed there was no transfer pole at the bedside. Interview with CNA #1 on 3/13/12 at 10 AM revealed the resident had not had the transfer pole by the bed for approximately one month. Interview with the DON on 3/14/12 at 1:25 PM revealed the transfer pole was placed by the resident's bed but s/he did not use it so it was removed. b. The care plan included the use of a walker;	F 280	The facility ensures that resident care plans are updated and reflect the resident's current status. The MDS Coordinator and the licensed nursing staff will be in serviced on the importance of revising the care plan to reflect the resident's current status as related to transfer status, use of transfer aides, continence status, assistance with meals, meals supplements, pressure ulcer risk and pressure ulcer interventions, restorative program participation, fall risk and fall interventions are in place as indicated. To be completed by the DNS/designee. Five random care plans will be audited each week to ensure that the transfer status, use of transfer aides, continence status, assistance with meals, meals supplements, pressure ulcer risk and pressure ulcer interventions, restorative program participation and fall risk and fall interventions are in place as needed x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	Resident care plans reflect current status

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

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	535861	A. BUILDING _____ B. WING _____	C 03/16/2012

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F 280	Continued From page 11 however, observation on 3/13/12 at 8:10 AM showed CNA #4 and RN #1 transferred the resident from the bed to his/her wheelchair using a sit-to-stand mechanical lift. The use of a sit-to-stand mechanical lift was not included as an approach in the current care plan. c. Interview with the DON on 3/14/12 at 1:25 PM verified this resident's care plan did not accurately reflect the current plan of care and needed to be updated. 2. Review of the 6/24/11 initial and the 9/12/11 and 12/30/11 quarterly MDS assessments for resident #44 showed s/he required supervision with one person physical assist for meals. Review of the 2/15/12 care plan showed the resident required set up and supervision with only occasional limited assistance. However, observation of the evening meal on 3/12/12 at 5:20 PM, breakfast on 3/13/12 at 7:54 AM and lunch on 3/14/12 at 12:30 PM showed the resident required total assistance of one for eating. Additionally, the physician ordered health shakes three times daily and finger foods as available which were not included in the care plan as interventions. Interview with LPN #2 and CNA #4 on 3/14/12 at 2:35 PM verified the care plan was not accurate based on the resident's current needs. 3. Review of the March 2012 nursing summary sheet for resident #25 showed s/he was occasionally incontinent of urine and needed supervision during transfers. Observation on 3/13/12 at 9:50 AM showed the resident was incontinent of urine and used an incontinence brief. Further observation showed the resident used a transfer board to move from the bed to	F 280		

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

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F 280	Continued From page 12 his/her wheel chair with one staff member assisting in the transfer. Review of the care plan that was last updated on "2/2012" showed it did not reflect these current needs of the resident. The care plan showed the resident required two people to transfer and with the use of a mechanical lift. Further, it showed the resident had a catheter in place for bladder drainage. 4. Review of the admission MDS assessment dated 2/10/12 for resident #18 showed s/he was at risk for developing pressure ulcers and needed assistance with ADLs. The following concerns with the care plan were identified: a. Review of the care plan showed the resident was at risk for pressure ulcers but there were no preventive measures identified. Observation on 3/13/12 at 8:30 AM showed the resident had a cushion on the seat of the wheelchair but the cushion was not included in the care plan. b. The care plan showed the resident received restorative services for ADL training. However, interview with the MDS coordinator on 3/15/12 at 9 AM confirmed the resident was not on a restorative program. Instead, the resident was receiving occupational and physical therapy. 5. Review of the undated care plan for resident #5 showed it was not updated to reflect the current status of the resident. The following concerns were noted: a. Review of the falls assessments for the resident showed s/he had fallen on 2/12/12 and 2/17/12. The resident was sent to the emergency room after each incident. Further review showed possible contributing factors included the resident would often forget to lock his/her wheel chair	F 280		

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

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F 280	Continued From page 13 during transfers. In addition the resident had a recent change in his/her medications that was identified as a possible contributing factor. Review of the resident's care plan for falls with a target date of "6/2012" showed s/he was only at risk for falls, it did not include any of the identified contributing factors or preventive measures for falls. b. The 2/22/12 quarterly MDS assessment showed the resident was at risk for developing pressure ulcers. The skin and ulcer treatments for the prevention of pressure ulcers included pressure reducing devices for his/her chair and bed. Review of the undated care plan for pressure ulcers showed it did not include any pressure reducing devices to be used to prevent the development of pressure ulcers. 6. An interview with the MDS coordinator on 3/15/12 at 9 AM revealed she was behind in updating resident care plans.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, and resident and staff interview, the facility failed to ensure 1 of 12 residents (#13) received	F 309	**F309-Care and Services for Highest Well-being** Resident #13 eye infection has resolved. The facility ensures that residents receive ongoing assessing and monitoring of ongoing acute infections. The licensed nursing staff will be in-serviced on the importance of assessing and then informing the primary	4-29-12

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

4/4/12

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F 309	Continued From page 14 ongoing assessments and monitoring as needed for an ongoing acute infection. The findings were: Review of a nursing note dated 2/9/12 for resident #13 revealed the resident complained of "left eye burning, drainage." The physician was notified and conjunctivitis was diagnosed. The resident was treated with a tobramycin eye solution for 5 days. Further review of the record revealed the physician was contacted via fax on 3/4/12 regarding the resident's eye. The fax from the facility showed, "resident's eyes have purulent, green matter, left worse than right. May I have something for them. Complains eyes itching, bothering [him/her]. Was on Tobramycin in February for same sign and symptoms." The physician responded five days later on 3/9/12 with a communication that showed "noted." The following concerns were identified: a. Observation on the first day of survey (3/12/12) at 4:01 PM revealed the resident was in his/her room. Upon approaching the resident, it was apparent the resident's left eye was inflamed with discharge. The resident stated at that time, the eye was "painful and itching." Additional record review revealed another faxed nurses' communication to the physician related to the residents eye dated 3/12/12. Review of the communication showed, "left eye red drainage irritation, ?conjunctivitis." An order for an appointment was received, and the resident was then seen and treated for the eye infection the following day (3/13/12), nine days after the 3/4/12 communication to the physician. b. Interview with the DON on 3/15/12 at 9:48 AM revealed the facility should have called the physician for an acute change of condition to obtain treatment in a more timely manner.	F 309	physician of signs/symptoms of an acute infectious process timely and to inform administrative nursing staff if the primary physician does not respond to the phone call/fax. To be completed by the DNS/designee. All residents experiencing an infectious process will be audited at morning report to ensure that the primary physician has been contacted and that the resident is receiving treatment x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	

4/4/12

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 medical record review, observation, staff interview and review of the facility's policies and procedures, the facility failed to ensure acceptable technique was used during 1 of 4 observations of perineal care, which affected sample resident (#25). The findings were: Review of the 1/23/12 admission MDS assessment for resident #25 revealed s/he needed extensive assistance with personal hygiene. Observation on 3/13/12 at 9:50 AM showed the resident was incontinent of urine. CNA #5 cleansed the resident's right buttock but did not cleanse his/her left buttock, anterior perineum and lower back where urine came in contact with the skin. During an interview with the CNA immediately following the observation, she acknowledged she was to cleanse all areas of the skin that came in contact with urine. Review of the facility's procedure for perineal care showed the buttocks, thighs, perineum and pubic areas were to be cleansed thoroughly.	F 312	**F312-ADL Care** Resident #25 has been discharged. The facility ensures that correct technique is utilized during resident incontinence/perineal care. The certified nursing assistants will be in-serviced on the correct technique in providing incontinence/perineal care. To be completed by the DNS/designee. Three random audits will be completed each week to ensure that correct technique of incontinence/perineal care is being utilized x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	4-29-12
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	**F323-Free from Accidents**	4-29-12

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F 323	Continued From page 16 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment in 2 of 31 resident rooms (#8 and #9) and in 1 of 1 secure care units (SCU). The findings were: 1. Observation on 3/14/12 between 11:48 AM and 1:14 PM revealed a 6 inch by 14 inch section of baseboard heater cover in resident room #9 that was pulled away from the wall exposing the metal heater behind it. In addition, the baseboard cover in the bathroom of resident room #9 was also coming away from the wall and exposed a sharp metal edge. The baseboard cover in resident room #8 also had become dislodged. 2. Periodic observations from 3/12/12 at 3:48 PM through 3/14/12 at 3:00 PM revealed the two handrails on each side of the door leading into the activities room in the SCU had gaps at the ends which created a pinching hazard for residents. The facility manager was interviewed on 3/14/12 at 1:48 PM and confirmed the observation. 3. Observation on 3/12/12 during tour of the SCU from 4 PM to 4:30 PM revealed a radio cord was hanging from a six foot high shelf in the dining room where residents could reach and pull the radio down upon themselves. The cord remained	F 323	Room #8 86 Resident # 8's ~~room~~ has had the baseboard cover secured properly. Room #9 86 Resident ~~#9's~~ room has had the bathroom baseboard cover has been secured properly as well as the baseboard heating cover. Resident #44 ~~is stable~~ is being supervised to prevent The hand railings outside of the activity room have been repaired. Facility staff will be in-serviced on the importance of reporting/documenting safety concerns to the maintenance director to ensure a safe environment is provided for the residents. To be completed by the DNS/designee. Five random resident room audits and hallway railing will be completed each week to ensure that a safe environment is being provided x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	

4/4/12

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F 323	Continued From page 17 there until 3/14/12 when it was secured in a way where residents were unable to reach it. Also in the SCU activities room, a television was sitting on an unstable TV stand. Observation on 3/13/12 at 8:15 AM revealed resident #44 attempted to push the television off the table. The television was not secured to the table it was sitting on and it was observed to move when the resident rocked it back and forth. Interview with LPN #2 and CNA #4 on 3/14/12 at 2:35 PM verified the unsecured television was a potential safety hazard. Interview with the facility manager on 3/14/12 at 11:52 AM revealed he was concerned about the above observations as they did represent safety hazards.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under five percent (%). Three errors occurred out of 44 opportunities for error, resulting in an error rate of 6.8%. The findings were: 1. Observation of medication pass on 3/14/12 at 7:30 AM revealed resident #40 had Spironolactone (diuretic, antihypertensive) 25 milligrams ordered for administration at 8 AM. Observation revealed the medication was not administered because according to LPN #1, it	F 332	**F332-Medication Errors** Residents # 40, #23 and #4 are stable. and are receiving meds as ordered. The facility ensures that the residents receive medications as per the physician's order. The licensed staff will be in-serviced on the five rights of medication administration. To be completed by the DNS/designee. Three random medication pass audits will be completed each week to ensure that the residents are receiving their medications as ordered by their physicians, and that the five rights of	4-29-12

DB 4/4/12

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F 332	Continued From page 18 was "on hold for now." However, review of all the physician's orders in the medical record revealed no evidence the Spironolactone should not be administered. Interview with LPN #1 at 12:05 PM on 3/14/12 revealed the computer was in error and the medication should have been administered. 2. Observation on 3/13/12 at 8:10 AM showed RN #3 prepared medications including Vitamin B-1 100 mg (milligrams) for administration to non-sample resident #23. Review of the resident's physician orders and the March 2012 medication administration record (MAR) with the RN on 3/13/12 at 10:40 AM verified the order was for Vitamin B-1 300 mg. The RN acknowledged at that time that the resident did not receive the correct dose of medication. 3. Observation on 3/14/12 at 7:30 AM showed RN #3 prepared medications including Senna (laxative) for sample resident #4. The medication bottle did not indicate the dose of the Senna contained in the bottle. Review of the resident's March 2012 MAR and the 3/12/12 physician orders with the RN at 3/14/12 at 11:20 AM showed the resident was to receive Senna 8.6 mg. The RN acknowledged the dose of the medication in the bottle needed to be verified by the pharmacist. According to Semla, Beizer and Higbee in "Geriatric Dosage Handbook," 12th Edition, 2007, the medication Senna was available in 8.6 mg, 15 mg and 25 mg tablets.	F 332	medication administration are being followed. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356	**F356-Nurse Staff Posting**	4-29-12

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F 356	Continued From page 19 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift. In addition, the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months. The findings were:	F 356	The facility nursing staff posting is updated at the beginning of each shift to ensure accuracy. The facility ensures that the nursing staff posting is timely and accurate. The facility also ensures that it will maintain a minimum of 18 months of nursing staff postings. The Director of Nursing and Administrator will be in-serviced on the importance of maintaining a timely and accurate nursing staff posting, as well as the federal requirement of maintaining a minimum of 18 months of the same posting. To be completed by the Corporate Clinical Specialist. A weekly audit of the nursing staff posting will be completed to ensure that the charge nurse is reviewing the sheet for accuracy, prior to the start of his/her shift x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	

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F 356	Continued From page 20 Review of the facility's daily staffing and census reports on 3/15/12 at 9:15 AM, located at the front entrance, showed it was completed for the entire day to include the evening and night shifts. Interview with the medical records director on 3/15/12 at 10:45 AM verified the staffing report was posted at the beginning of the day for the next 24 hours. Any changes to the daily staffing report were made the following day. In addition, the facility only had 14.5 months of the daily nurse staffing schedules on file.	F 356		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	**F441 – Infection Control – Linen** Resident #13 eye infection has resolved. ~~Resident # 21 is stable.~~ Residents #21, 39, 46 are BS checks completed w/ a discrepant level The facility ensures that resident infections are tracked by the infection control program. The facility ensures that proper hand washing technique is utilized by the staff to prevent the spread of infection. The facility ensures that the glucometer is disinfected between resident use to prevent the spread of infection. The infection control nurse will be in serviced on the facility policy to track	4-29-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535051	A. BUILDING _____ B. WING _____	C 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

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F 441	Continued From page 21 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) 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 and resident interview, medical record review, review of infection control logs, policy and procedures, and review of manufacture's instructions, the facility failed to ensure 1 of 9 sample residents (#13) who was identified with an infection was tracked by the infection control program. In addition, there was a lack of hand hygiene during two random observations, and failure to effectively disinfect glucometers (device used to test blood sugar) during 3 of 3 observations. Finally, the program lacked an effective monitoring system to ensure appropriate hand hygiene and personal care was practiced by staff. The findings were: 1. Review of the infection control surveillance logs for February and March 2012 showed information about residents with identified infections. The information included the onset date, the culture date, the site of the infection, risk factors, precautions, the organism, the date cleared, and an area for comments where the infection control coordinator (ICC) listed the	F 441	resident infections to ensure that the resident receives timely treatment. To be completed by the DNS/designee. The licensed nursing staff will be in-serviced on the policy and procedure for hand washing and on the proper procedure for disinfecting glucometers between resident use, to prevent of the spread of infection. To be completed by the DNS/designee. All residents experiencing an infectious process will be audited at morning report to ensure that the resident is being tracked by the infection control program and is receiving treatment x 90 days. To be completed by the DNS/designee. Three random observational audits will be completed each week to ensure that licensed nursing staff is washing their hands as per facility policy and disinfecting glucometers between resident use, to prevent the spread of infection x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	

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F 441	Continued From page 22 treatment being used. Interview with the ICC on 3/14/12 at 3:15 PM revealed she was provided information on residents with infections on a daily basis from the nursing staff. She tracked the infections to ensure the appropriate treatments were being provided. She stated the information on the surveillance log was documented as she became aware of it. The following concerns were identified: a. Review of the 2/9/12 nurses note for resident #13 showed s/he had an eye infection that was treated with an antibiotic Review of the February 2012 infection control log failed to include this resident. Interview with the ICC on 3/14/1 at 3:15 PM revealed she was aware of the infection and knew it was treated; however, was not sure why the information was not included on the log. b. Review of the March 2012 infection control log showed resident #13 was listed as having an eye infection with an onset date of 3/3/12. Review of the record revealed the physician was contacted via fax on 3/4/12 regarding the resident's eye. The fax from the facility showed, "resident's eyes have purulent, green matter, left worse than right. May I have something for them. Complains eyes itching, bothering [him/her]. Was on Tobramycin in February for same sign and symptoms." The physician responded five days later (3/9/12) with a communication that showed "noted." Observation on the first day of survey (3/12/12)at 4:01 PM revealed the resident was in his/her room. Upon approaching the resident, it was apparent the resident's left eye was inflamed with discharge. The resident stated at that time, his/her eye was "painful and itching." Review of a nursing communication dated 3/12/12 showed the physician was notified again regarding the	F 441		

4/4/12

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F 441	Continued From page 23 resident's signs and symptoms of an eye infection The resident was seen the following day (3/13/12) and treated by the physician. Interview with the ICC on 3/14/12 at 3:15 PM revealed the time between the onset of the resident's symptoms and treatment was not timely. She further revealed the facility had not considered the possibility of the infection being contagious. 2. Interview with the ICC on 3/14/12 at 3:15 PM revealed she provided education to staff related to infection control issues. The education included hand hygiene and personal care techniques. The ICC revealed the monitoring done to determine staff competency was to ask them for a demonstration. She did not, however, perform unannounced observations to monitor actual practice. Observation on 3/13/12 between 8:15 AM and 8:30 AM showed RN #3 washed her hands then touched her hair on two separate occasions before preparing medications for non-sample residents #23 and #24. During an interview with the RN on 3/14/12 at 8:50 AM acknowledged she was not to touch her hair after she had washed her hands and before she prepared medications. Review of the facility's policy for hand washing showed the staff should wash their hands after handling contaminated items to prevent the spread of infection. 3. Review of the manufacturer's instructions for cleaning and disinfecting the Quintet glucose meter showed the meter was to be disinfected with household bleach with a 1 to 10 part dilution (bleach to water). The following concerns were noted: a. During an observation on 3/14/12 at 11:40 AM showed LPN #1 took the Quintet blood	F 441		

4/4/12

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F 441	Continued From page 24 glucose monitor to the room of sample resident #39 and placed it on his/her bedside table. The LPN performed the glucose blood test then returned the glucometer to the medication cart. She placed it directly into a drawer of the cart before cleaning it. Interview with the LPN at that time revealed she was not sure when the glucometer was to be cleaned or how to clean it. b Observation on 3/14/12 at 12:05 PM showed LPN #1 placed a glucometer in the top drawer of the medication cart after using it to test the blood sugar for non-sample resident #46. The LPN then took the glucometer out of the drawer and used an alcohol wipe to clean it and replaced it in the medication cart drawer. She stated it was a multiuse glucometer. Interview with the LPN at the time revealed this was her normal routine for cleaning glucometers. c. Observation on 3/14/12 at 11:55 AM showed RN #3 took a blood glucose monitor to the room of non-sample resident #21. After the RN completed the blood glucose test, she cleaned the glucometer with an alcohol wipe. d. An interview with the DON on 3/15/12 at 10 AM revealed she was not aware of the appropriate method to disinfect a glucometer after it had been used for blood glucose testing.	F 441		
F 496 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and	F 496	**F496-Nurse Aide Registry** C.N.A's #1, #2 and #3 have been verified through the Nurse Aide Abuse registry.	4-29-12

88 4/10/12

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F 496	Continued From page 25 competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on review of personnel files and staff interview, the facility failed to review the State nurse aide abuse registry before hiring 3 of 3 CNAs (#1, #2, #3). The findings were: Review of personnel records on 3/14/12 at 3:25 PM for CNAs #1, #2 and #3 failed to show evidence the State nurse aide abuse registry was checked for findings of abuse or neglect prior to their hiring date. The business office manager confirmed in an interview on 3/14/12 at 4:01 PM she was unaware the nurse aide abuse registry was required to be reviewed prior to hiring CNAs.	F 496	The facility ensures that all certified nursing assistants are verified through the Nurse Aide Abuse Registry prior to hire. The Director of Nursing and the Business Office Manager will be in-serviced on the importance of verifying all certified nursing assistants through the Nurse Aide Abuse registry prior to hire to ensure compliance with Wyoming law. To be completed by the Administrator/designee. A weekly audit will be completed on all certified nursing assistant employment applications to ensure they have been verified through the Nurse Aide Abuse registry prior. To be completed by Administrator/designee. Audit findings will be reviewed at the QA meeting.	

4/16/12

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F 507 SS=D	483.75(l)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS 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 the results of a laboratory test were in the medical record for 1 (#42) of 12 sample residents. The findings were: Review of the 1/19/12 physician's order for resident #42 revealed an order for a complete blood count (CBC). Review of the entire medical record revealed the results of the test were not in the medical record. Interview with the DON on 3/15/12 at 10:50 AM revealed she had to call the laboratory to obtain a copy of the results. Review of the report showed abnormal laboratory values.	F 507	**F507-Lab Reports** Resident #42 is stable, and labs have been filed in the Records The facility ensures that all physician ordered lab work results are maintained in the medical record. The licensed nurses will be in-serviced on the importance of maintaining all physician ordered lab work results into the medical record. To be completed by the DNS/designee. Three random charts of those residents having physician ordered lab work will be audited each week to ensure the results are maintained in the medical record x 90 days. To be completed by the DNS/designee. Audit findings will be reviewed at the QA meeting.	4-29-12