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

PRINTED: 03/15/2012
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
	560090	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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
P 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA - certified nursing assistant DON - director of nursing foley - indwelling urinary catheter LPN - licensed practical nurse MAR - medication administration record MDS - Minimum Data Set MRSA: Methicillin-resistant Staphylococcus aureus (a drug-resistant bacterium) QAPI - quality assurance performance improvement RN - registered nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (B) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of medical records, the facility failed to ensure the advanced directive request for 1 of 14 sample residents (#37) was reviewed and approved in a timely manner. The findings were: Review of resident #37's medical record on 2/29/12 at 2:30 PM showed s/he had requested a change in his/her advanced directives; the	F 155	**F-155 RIGHT TO REFUSE, FORMULATE ADVANCE DIRECTIVES** **Corrective Action:** Resident # 37 has had his/her Advance Directives reviewed and approved by the attending Physician and added to the Medical Record. The Interdisciplinary Team (IDT) was educated by the ED on the facility policy and procedures regarding Advance Directives. **Identification of Others:** The Advance Directives for current Residents' were reviewed by the IDT for completeness and appropriate Physician signature. Advance Directives were updated if needed.	4/23/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/23/12

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.

APR 13 2012

Healthcare Licensing and Surveys

This POC accepted. Corrections & changes on 4/16/12 @ 1015 per phone conversation c Tony Tanos, ED, and Betty Nelson, RN, State Health Surveyor

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

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F 156	Continued From page 1 change was from a do not resuscitate (DNR) status to cardiopulmonary resuscitation (CPR) with limited interventions to maintain life. The resident's written request for the change was dated 2/16/12 and as of 3/1/12 the request had not been reviewed or approved (signature of physician required). It was further noted at this time that the power-of-attorney listed on the resident's admission facesheet did not include any contact information. The social worker stated in interview on 2/29/12 at 2:55 PM the resident's request should have been reviewed and validated by a physician; she did not know why the physician had failed to acknowledge the resident's wishes. The social worker stated the facility had been unable to contact the resident's POA and was considering other arrangements to assist the resident with personal and medical decisions. No other arrangements had been accomplished since the resident's most recent admission on 2/14/12.	F 165	Systemic Changes: Advance Directives are reviewed upon admission, re-admission, and quarterly by the Admissions Coordinator/designee. The IDT will review the Advance Directives following admission to determine if the Physician has reviewed and signed the directives. Follow-up will be done with the physician and/or legal representative as needed. Advanced Directives will be reviewed by the IDT team during the quarterly Care Plan meeting to determine if the resident and/or legal representative desire changes to current directives and if the directives are signed by the physician. Appropriate corrective action will be taken as needed. Monitoring: During morning briefing, the IDT will review the Advance Directives following	
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 other facility staff to the State nurse aide registry or licensing authorities.	F 225	admission/re-admission, quarterly assessments and change of condition for compliance and report the results to the Performance Improvement (PI) Committee for further review and evaluation for corrective action until resolved. F-225 INVESTIGATE/REPORT/ALLEGATIONS/INDIVIDUALS Corrective Action: The nurse aide registry has been checked for any findings of abuse, neglect, mistreatment of residents, or	4/23/12

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F 225	Continued From page 2 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 staff interview, employee record review, and review of policy and procedure, the facility failed to ensure the nurse aide registry was checked for any findings of abuse, neglect, mistreatment of residents, or misappropriation of resident property for 3 of 3 CNAs (#1, #2, #3) whose records were reviewed. The findings were: Review of the facility policy and procedure, "POL 504-01" dated 2/28/08, on abuse compliance guidelines showed, "...9. Investigations into the past histories of a potential employee include: a.	F 225	misappropriation of resident property for CNAs #1, 2 and 3. There were no reports filed. The SDC was educated on the nurse aide registry and the requirement for use. The need to check the nurse aide registry prior to hiring nurse aides has been added to the nurse aide orientation checklist. **Identification of Others:** The nurse aide registry has been checked for all nurse aides currently working in the facility by the SDC. There were no reports filed. **Systemic Changes:** The SDC/designee will check the nurse aide registry for nurse aide applicants for any findings of abuse, neglect, mistreatment of resident, or misappropriation of resident property prior to the nurse aide's hiring. **Monitoring:** The Payroll/Benefits Coordinator (PBC) will audit the newly hired nurse aides file for compliance. Identified concerns will be reported to the DNS for immediate corrective action. The results of the audits will be reported to the PI Committee monthly for further review and evaluation for corrective action until resolved.	

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F 225	Continued From page 3 Inquiry of the state nurse aide registry or licensing authority..." The following concerns were noted when CNA employee files were reviewed: a. Review of the employee file for CNA #1 showed a date of hire on 1/31/12. The file showed background screening; however, there was no evidence the state nurse aide registry was checked for any findings of abuse. b. Review of the employee file for CNA #2 showed a hire date of 1/13/12 with no evidence the nurse aide registry was checked. c. Review of the file for CNA #3 showed a hire date of 12/31/11 with no evidence the nurse aide registry was checked. Interview with RN #7 on 3/1/12 at 10:04 AM revealed she had been in charge of the employee files since November 2011. She stated she was not aware of the nurse aide abuse registry. At that time, she verified the nurse aide abuse registry had not been checked for any CNAs in the facility.	F 225		
F 279 SS=E	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	F 279	F-279 DEVELOP COMPREHENSIVE CARE PLANS Corrective Action: The care plans for residents' #39and #5 were updated to reflect appropriate interventions for MRSA infections. Resident #18's UTI has been resolved. Education was provided to the nurses regarding the facility policy and procedure on completing and updating comprehensive care plans to reflect changes in a resident's status. Identification of Others: Care plans for current residents have been reviewed and updated where necessary to reflect the current status of the resident and appropriate interventions.	4/23/12

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F 279	Continued From page 4 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 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 develop and implement care plans for 3 of 3 sample residents (#5, #18, #39) with infections. The findings were: 1. Resident #39 was placed on contact precautions on 2/28/12 for MRSA in a Stage 3 pressure ulcer. However, that information had not been included in the care plan when reviewed by the interim DON on 3/1/12 at 9:03 AM. At that time, the DON confirmed the infection and resultant contact precautions should have been added to the care plan. 2. Review of a laboratory report dated 2/24/12 for resident #5 showed s/he had a wound infection that was positive for MRSA. Observation on 2/28/12 at 6:05 PM showed an isolation caddy on the door of the resident's room that contained personal protective equipment. Review of the 2/7/12 care plan on 3/1/12 at 9:30 AM failed to show any information information regarding the resident's wound infection with MRSA and the precautions the staff were to take in caring for the resident. 3. According to laboratory results dated 1/5/12, resident #18 had a urinary tract infection (UTI).	F 279	**Systemic Changes** Care plans are initiated by the IDT upon admission, significant change of status and as needed, based on resident status. Comprehensive care plans are reviewed and revised by the IDT upon admission, quarterly and upon significant change of status during care conference. Education is provided to nurses and the IDT related to the care plan process upon hire and as needed. **Monitoring:** The MDS Coordinator (MDSC)/designee will review the 24-Hour Change of Condition Report book 4-5 times per week for residents who have a change in status and determine if the care plan has been updated. Based on the results of the audit, additional training will be provided to the nurses and/or IDT. These audits will be done for two months and then re-evaluated. The results of the audits will be reported to the PI Committee monthly for review and evaluation for corrective actions until resolved.	

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F 279	Continued From page 5 Review of the care plan showed this infection was never addressed. On 2/29/12 at 3:56 PM, RN #4 verified the care plan had not been revised to include interventions to help resolve the UTI or to prevent recurrence.	F 279	F-280 RIGHT TO PARTICIPATE PLANNING CARE-REVISED CP Corrective Action: The care plan for resident #2 was updated to reflect the foley catheter.	4/23/12
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 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, medical record review, and staff interview, the facility failed to ensure staff revised care plans for 3 of 12 sample residents (#2, #29, #39) to accurately reflect each resident's current status. The findings were:	F 280	The care plan for resident #29 was updated to reflect the discontinued use of adaptive silverware. The care plan for resident #39 was updated to reflect appropriate interventions related to bowel and bladder care, including use of a foley catheter, mobility, and assistance needed with dressing. Education was provided to the nurses regarding the facility policy and procedure on completing and updating comprehensive care plans to reflect changes in a resident's status. Identification of Others: Care plans for current residents have been reviewed and updated where necessary to reflect the current status of the resident and appropriate interventions. Systemic Changes: Care plans are initiated by the IDT upon admission, significant change of status, quarterly, and as needed, based on resident status. Comprehensive care plans are reviewed and revised by the IDT upon admission	

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F 280	Continued From page 6 1. Observation on 2/27/12 at 5:45 PM showed resident #2 had a foley catheter. Review of the nurse's notes showed the foley catheter was inserted on 2/22/12. Review of the resident's 1/26/12 care plan for "Self-Care Deficit: Toileting" showed the resident was incontinent of urine. The care plan did not show the resident had a foley catheter. Interview with the MDS coordinator on 3/1/12 at 9:15 AM revealed the care plan had been updated in the computer to show the resident had a foley catheter but had not been printed to make it available to the nursing staff. 2. Review of the 2/28/11 care plan for resident #29 revealed staff were to provide adaptive silverware for each meal. Observation on 2/29/12 at 11:45 AM showed the resident ate with regular silverware. During an interview on 3/1/12 at 9:58 AM, LPN #6 stated the resident no longer used adaptive silverware and the care plan needed to be revised. 3. According to the 1/26/12 care plan, resident #39 was incontinent of urine but able to voice the need to urinate, followed a toileting plan for bowel continence, was able to select clothing and assist with dressing, and was able to assist with transfers. In addition, one of the goals for mobility was for the resident to self-propel the wheelchair to meals. Observation throughout the survey showed the resident had a foley catheter, was incontinent of bowel, demonstrated no interest in clothing and did not assist with dressing, and was totally dependent on staff for wheelchair motility. On 2/28/12 at 1:30 PM RN #12 confirmed that the care plan needed to be revised as the resident's condition had declined.	F 280	quarterly and upon significant change of status during care conference Education is provided to nurses and the IDT related to the care plan process upon hire and as needed. Monitoring: The DNS/Designee will review ten Activity of Daily Living (ADL) flow record three times per week to identify residents who have had a change in their care needs. Based on this review, care plans will be implemented and/or revised to reflect the current status of the resident and additional training will be provided to the nursing and IDT staff. The results of the reviews will be reported to the PI Committee monthly for review and evaluation for corrective actions until resolved.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	F-309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Corrective Action: Residents #2 and #5 have had a daily bowel monitor placed on their MAR's and a bowel elimination protocol was implemented to promote bowel regularity. Resident #2 and physician has been notified of the untimely administration of Hydromorphone 2 mg for pain.	4/23/12

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F 309 89=E	Continued From page 7 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 interviews, the facility failed to ensure 2 of 12 sample residents (#2, #5) were assessed and received treatment for constipation and 1 of 12 sample residents (#39) received the required treatment for an infection in a timely manner. In addition, the facility failed to either administer a prescribed medication in a timely manner or document the rationale of treatment for 2 of 12 sample residents (#2, #9) who had pain. The findings were: 1. Based on medical record review, resident #2 had diagnoses to include generalized pain, constipation, arthrosclerosis, and rheumatoid arthritis. Review of the resident's 1/25/12 care plan for constipation showed s/he was at risk for constipation due to use of pain medications. Further, the care plan showed the resident was to have a bowel movement at least every 3-4 days and "administer medication as ordered." In addition, the physician was to be notified "if problem with having a BM [bowel movement]." Review of the February MAR showed the resident had the pain medication hydrocodone	F 309	Resident #39's genital drainage has been resolved. The physician and resident's family had been made aware of the unavailability of 1 of 2 antibiotics at the time of the physician order. The LN staff and nursing aides have been educated on the facility's procedure for bowel monitoring, management and documentation, including the bowel elimination protocol. The LN staff has been education on the following: -The timely acquisition of physician ordered medications -The facility procedure for physician ordered medications not immediately available through current vendors -The Pain Management Policy and Procedure, including the pain scale, for proper administration of pain medications. **Identification of Others:** The facility's current residents have had a bowel monitor placed on their MARs and a bowel elimination protocol was implemented to promote bowel regularity. An audit of the past one week's physicians' orders was completed and there were currently no residents with physician ordered medications that are unavailable for administration in a timely manner.	

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F 309	Continued From page 8 with acetaminophen 5/500 mg (milligrams) ordered every six hours to be given for pain as needed. Review of the nurses' notes dated 2/27/12 at 8 PM showed a new order was received from the physician for hydromorphone 2 mg to be given every six hours as needed for pain. The following deficient practices were identified: Related to constipation: a. Review of the February ADL (activities of daily living) flowsheet for bowel and bladder function showed the resident did not have a bowel movement from 2/8/12 through 2/14/12 (7 days), and from 2/23/12 through 2/27/12 (5 days). b. Review of the February 2012 MAR showed the resident had Milk of Magnesia ordered as needed for constipation. Further review showed no evidence the resident received the medication for the entire month. c. While reviewing the February 2012 ADL flowsheet with LPN #6 on 3/1/12 at 9:15 AM, she acknowledged the resident's bowel movements were to be documented on the ADL flow sheet. She further acknowledged the flow sheet showed the resident had not had a bowel movement for several consecutive days. Related to pain: a. During an interview with the resident on 2/28/12 at 10:46 AM, s/he stated his/her current pain level was 8 to 10 on a scale of 1 to 10 with 10 being the worst pain. Observation of the resident at that time showed s/he was grimacing. The resident stated a stronger pain medication (hydromorphone) was ordered but it had not arrived. Review of the February 2012 MAR showed the resident received his/her last dose of hydrocodone with acetaminophen at 10 AM, 45 minutes earlier. Interview with LPN #6 on	F 309	An audit of the pain flow sheets for current residents was completed and education of LN staff on pain medication administration was done when necessary. Systemic Changes: The DNS will be notified regarding a physician ordered medication which is unavailable for timely administration and if after physician notification no alternative medication or alternative therapy was ordered for timely resolution. The DNS will contact the alternative sources locally in order to obtain the medication for timely administration. These instances will be presented to the IDT/pharmacy vendor on the next business day for review and evaluation for corrective action. Monitoring: The DNS/Designee will audit the MARs and ADL Flow Sheets for documentation related to bowel monitoring and to determine if appropriate interventions implemented. This will be done weekly for four weeks and then will be re-evaluated. The DNS/Designee will audit ten MAR's for pain monitoring flow sheets to determine pain medication administration and pain scale compliance, availability of medication, and timeliness and accuracy of administration. This will be done 3-5 times a week for four weeks and then will all medication by	

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 16TH STREET RAWLINS, WY 82301

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F 309	Continued From page 9 2/28/12 at 10:40 AM, revealed the hydromorphone had been ordered the previous night from a pharmaceutical company located out of state. Further, she confirmed the pain medication had not arrived. b. Interview with LPN #6 on 2/28/12 at 10:55 AM revealed the resident had just received the prescribed pain medication, 14 hours and 55 minutes after the order was received. The LPN stated she was not aware she could call the pharmacy and obtain permission to access hydromorphone from the facility's "emergency kit." c. Interview with LPN #6 on 3/1/12 at 10:15 AM revealed the prescribed hydromorphone arrived from the out-of-state pharmacy on 2/29/12 at 10 AM, 38 hours after the order was written. 2. Review of the care plan dated 2/6/12 showed resident #5, determined by the facility to be cognitively impaired, was at "Risk for impaired bowel elimination: constipation r/t impaired mobility, use of cardiac, pain and psychoactive medications." Review of the February 2012 MAR showed the resident had an order for MiraLax (for constipation) 17 gm (grams) to given in 8 ounces of juice three times a week. The following concerns were identified: a. Review of the February 2012 MAR showed the resident had refused his/her Miralax from 2/15/12 through 2/27/12. b. Review of the ADL flow sheet for February 2012 showed no documentation the resident had a bowel movement from 2/16/12 through 2/28/12 (eleven days). c. Review of the nurses' notes and the nurse's aide notes from 2/16/12 through 2/28/12 showed there was no documentation to show the resident had a bowel movement during	F 309	be re-evaluated. Based on the results of the audits, immediate corrective action will be taken and additional training will be provided to the nurses. The results of the audits will be reported to the PI Committee for review and evaluation for corrective action until resolved.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	535036	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 10TH STREET RAWLINS, WY 82301

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F 309	Continued From page 10 that time frame. d. Interview with LPN #6 on 3/2/12 at 9:15 AM revealed she relied on the residents themselves or on the CNAs to report if someone had not had a bowel movement. The LPN stated constipation for cognitively impaired residents could be missed if they did not have bowel movements for several consecutive days. 3. According to a filed laboratory result, resident #39 had a culture obtained on 1/19/12 for genital drainage. The preliminary results were listed as Staphylococcus aureus and non lactose fermenting gram negative bacilli. The final results were unchanged and, per interview with the performing laboratory manager on 2/28/12 at 2:20 PM, were sent to the facility on 1/23/12. However, for an unknown reason, treatment was delayed until 1/26/12, a week after the culture was first obtained. 4. Review of resident #9's medical record on 2/28/12 at 10:10 AM showed the resident received a pain medication (Ultram) as needed to manage pain. The MAR showed Ultram was administered to the resident on 2/14/12. However, the pain management flowsheet showed the resident's pain level was "0" prior to administering the medication and was again assessed as "0" following administration. Interview with LPN #6 on 2/29/12 at 1:45 PM revealed the resident "...must have had something going on...or else we would not have given [him/her] anything for pain..." The LPN was not sure why the resident's pain level had been documented at zero (no pain).	F 309	**F-315 NO CATHETER, PREVENT UTI, RESTORE BLADDER** **Corrective Action:** The LN staff and nurses aides were educated on the facility's policy "Urinary Catheter Care" PRO 66201-03 by the Staff Development Coordinator (SDC). **Identification of Others:** Rounds were conducted over three days, at different times during day, to observe residents with indwelling urinary catheters to determine proper placement and positioning of their urinary catheter drainage bag. No problems were identified. **Systemic Changes:** During cares with residents who have indwelling catheters, nursing staff are to ensure the proper positioning of the catheter bag to prevent drainage issues and potential infections. **Monitoring:** The SDC/designee will conduct rounds 3-5 times per week for one month then weekly for four weeks to observe	4/23/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER.	F 316		

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F 315	Continued From page 11 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, medical record review, staff interview, and review of the facility's policies and procedures, the facility failed to ensure a resident with a foley catheter received the appropriate treatment and services for 1 of 4 sample residents (#2) who had a catheter. The findings were: Review of the medical record showed resident #2 had diagnoses to include an open wound to the buttock, congestive heart failure, and edema. Review of the 2/13/12 "Evaluation of Medical Justification for Indwelling Catheter Use" showed the resident had a foley catheter placed to accurately measure urine output and reduce contamination of his/her pressure ulcer. The following concerns were identified: a. Observation on 2/28/12 at 5:30 PM showed the resident in his/her room with the foley catheter hanging at waist level from the wheelchair. The urine could not drain into the urine collection bag. Observation at 5:50 PM, 20 minutes later, showed the drainage bag remained	F 315	positioning of the catheter tubing and drainage bags. The SDC/Designee will address any identified non-compliance with the staff member immediately upon observation. The results of the rounds will be reported to the PI Committee for review and evaluation for corrective action until resolved. F-387 FREQUENCY AND TIMLINESS OF PHYSICIAN VISIT Corrective Action: The untimely physician visit for residents #18, #29, and #39 occurred in the past and cannot be resolved. The three residents' physicians are now in compliance with their visits to these residents. Education was done with the Health Information Manager (HIM) regarding the facility policy and procedure related	4/23/12

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F 315	Continued From page 12 at the same level. Interview with LPN #6 at that time confirmed the foley catheter was not positioned properly to allow the bladder to drain. b. Observation on 2/29/12 at 9:40 AM showed the resident had his/ her foley catheter bag on the floor of his/her room. Further, the bag was not covered. Interview with CNA #10 on 3/1/12 at 9 AM revealed foley catheter bags were not to be placed on the floor. Further, she stated proper placement was necessary to prevent "UTIs." c. Review of the policy "Indwelling Urinary Catheter Care" PRO 66201-03, dated 4/29/10, showed the position of the collection bag was to be below the level of the bladder at all times. Further, the policy instructed, "Do not rest the bag on the floor."	F 315	to physician visits and to notify the Executive Director (ED)/Director of Nursing Services (DNS) as problems are identified. **Identification of others:** The physician visit schedule was reviewed and physicians were notified of visits needed. Physician visits are current. **Systemic Changes:** The facility policy for physician visits and a copy of F-387 from the 2567 have been delivered to all attending physicians with a letter explaining the requirement for visits.	
F 387 SS=E	483.40(a)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 3 of 12 sample residents (#18, #29, #39) were seen by a physician as required. The findings were: 1. Review of the medical record showed resident	F 387	The HIM will track physician visits monthly. A calendar of the previous month will be sent out to each attending physician denoting which resident needs to be seen and by which date. Seven to ten days prior to the visitation date the HIM sends a reminder to physicians. If the physician does not visit by the due date the HIM notifies the DNS who then calls the physician to remind him/her of their obligations for timely physician visits. The ED/Designee will be notified of non-compliant physicians for immediate corrective actions. **Monitoring:** The HIM/designee will report the status	

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F 387	Continued From page 13 #16 was admitted on 6/24/11. Review of the physician's notes showed the first visit occurred on 9/2/11. There was no evidence the physician saw the resident every thirty days for the first ninety days as required. On 3/1/12 the interim DON confirmed the physician did not see the resident prior to 9/2/11. 2. According to the medical record, resident #29 was admitted on 6/30/11. The first documented physician visit after this admission was dated 9/7/11, and the next was 12/7/11. Neither the requirement for physician visits every thirty days for the first ninety days after admission nor the requirement for visits every sixty days thereafter was met. On 2/29/12 at 1:16 PM the interim DON stated there was no evidence of other physician visits. 3. Review of the medical record showed resident #39 was admitted on 11/26/11, but physician visits occurred on 12/20/11 and 2/25/12. There was no evidence a physician saw the resident in January 2012. On 2/29/12 at 1:16 PM, the interim DON confirmed a physician did not see the resident as required.	F 387	of physician visits to the PI Committee monthly for two months and then re-evaluate. The PI Committee will provide further recommendations as needed.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	**F-425 PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH** **Corrective Action:** The medications for residents #2 and #39 were received and have been available. **Identification of Others:** An audit of the last week's physicians' orders was completed and there are currently no residents with physician ordered medications that are unavailable for administration in a timely manner. **Systemic Changes:** The DNS will be notified regarding a physician ordered medication which is unavailable for timely administration and if after physician notification no alternative medication or alternative therapy was ordered for timely resolution. The DNS will contact the alternative sources locally in order to obtain the medication for timely administration. These instances will be presented to the IDT/pharmacy vendor the next business day for review and evaluation for corrective action. The SDC/Designee will educate newly	4/23/12

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F 425	Continued From page 14 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to implement an effective system for obtaining medications in a timely manner for 2 of 12 sample residents (#2, #39). The findings were: 1. Review of the medical record showed resident #2 had diagnoses to include arthrosclerosis, rheumatoid arthritis, and generalized pain. Review of the nurses' notes dated 2/27/12 at 8 PM showed an order was received from the physician for hydromorphone 2 mg (milligrams) to be given every six hours as needed for pain. An interview with LPN #6 on 3/1/12 at 10:15 AM revealed the process for obtaining medication was as follows: An order for a medication needed to be received by the out-of-state pharmaceutical company by 4 PM if it was to be delivered to the facility the next day. If the order was written after 4 PM, it would not be delivered until the following day (approximately 40 hours after being ordered). She also revealed medication could be obtained locally but the local pharmacy closed at 5:30 PM.	F 425	hired LN related to the facility policy and procedure for medication administration and measures to take if a medication is not available, upon hire and as needed. Monitoring: The DNS/Designee will audit Medication Administration Records (MAR), new physician orders, and the 24 hour Change of Condition report 3-5 times per week to identify potential delay in medication administration due to unavailability. Immediate corrective action to resolve the delay will be taken. Based on this audit, additional training will be done with the nurses and evaluation of a potential need to update the E-Kit medications will be discussed with the Pharmacy Vendor. This will be done weekly for four weeks and then re-evaluate. The DNS/designee will report the results of the audits to the PI Committee monthly for further review and evaluation for corrective action until resolved.	

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F 425	Continued From page 15 The facility had some back-up medications located in locked boxes, or "emergency kits", but not all the new medications ordered by the physician were located in those boxes. The following concerns were identified: a. During an interview on 2/28/12 at 10:45 AM, the resident stated his/her pain level was 8 to 10 on a scale of 1 to 10 with 10 being the most severe pain. Observation at that time showed the resident was grimacing. The resident also stated awareness that a stronger pain medication had been ordered but had not arrived. During an interview on 2/28/12 at 10:40 AM, LPN #6 stated the stronger pain medication, hydromorphone, had been ordered the previous night from an out-of-state pharmaceutical company. Further, the LPN stated the pain medication had not arrived. b. On 2/28/12 at 10:55 AM LPN #6 stated she was not aware she could call the out of state pharmacy to obtain permission to access the hydromorphone contained in the facility's "emergency kit." c. Interview with the LPN on 3/1/12 at 10:15 AM revealed the hydromorphone arrived from the out of state pharmacy on 2/29/12 at 10 AM, 38 hours after the order was written. 2. Review of orders dated 2/24/12 for resident #39 showed the physician ordered Bactrim twice daily and Clindamycin three times a day for an active infection. The orders were noted on 2/25/12 at 2:10 PM, and the Bactrim was started that evening. However, the Clindamycin was not started until 11:30 AM on 2/27/12, three days after the initial order was written and two days after the order was noted. On 2/29/12 at 2:32 PM, RN #12 stated the medication was not started	F 425	F-431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS **Corrective Actions:** The Latanoprost ophthalmic solution and the tuberculin solution vials have been disposed of per facility policy. The LN staff had been educated on the facility policy on multiple dose medication labeling and adherence to the manufacturer's information sheet. **Identification of Others:** Multiple dose medication vials have been checked for labeling and dating per manufacturer's information. Medications not in compliance were disposed of per facility protocol. The medication refrigerators were checked for unlabeled or outdated medication vials. Medications not in compliance were disposed of per facility protocol. Systemic Changes: All multiple dose vials are to be labeled with permanent marker the date in which they are opened by the LN. They are disposed of according to the	4/23/12

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F 425	Continued From page 16 until 2/27/12 because it did not arrive until then. She further stated it was not available in the facility's emergency kit.	F 426	Manufacture's instructions. During the evening shift the incoming and outgoing LN will check all multiple dose vials in the medication cart, refrigerator, and glucometer case for compliance with the policy and initial upon completion. Any noncompliant vials will be given to the SDC/Designee and corrective actions taken. Monitoring: The SDC/Designee will audit nursing carts and medication refrigerators, and monitoring log, weekly for unlabeled or improperly labeled medications. Unlabeled or improperly labeled medications will be disposed of per facility policy. Immediate corrective actions will take place when appropriate. Results of the audit will be presented to the PI Committee monthly for review and evaluation for corrective action until resolved.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the manufacturer's instructions, the facility failed to ensure opened containers of medication intended for multiple use were dated when opened. This involved storage areas located at 1 of 2 nurses' stations. The findings were: 1. Observation on 2/29/12 at 4:20 PM showed the medication cart located at the front nurses' station had the medication Latanoprost ophthalmic solution, for non-sample resident #50. The medication was not labeled with the date it was opened. Interview with LPN #6 at that time confirmed the medication was not dated and it was available for use. According to the manufacturer's information, "Once a bottle is opened for use, it may be stored at a temperature up to 25 C [Celcius] (77F [Fahrenheit]) for 6 weeks." 2. Observation on 2/29/12 at 4:30 PM showed the refrigerator located at the front nurses' station had one multiple-use vial of tuberculin solution that was not labeled and initialed to show when it was opened. Interview with LPN #6 at that time confirmed the vial did not indicate the date it was opened and it was available for use. According to Smith, Duell and Martin in "Clinical Nursing Skills Basic to Advanced Skills" seventh addition, 2008, page 606, "If multiple-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials."	F 431	F-441 INFECTION CONTROL, PREVENT SPREAD, LINENS Corrective Action: The January 2012 Infection Control log was updated to reflect the information for the six identified residents. The February 2012 Infection Control log was updated with the culture results for the two identified residents. The SDC was educated on the following: -Infection surveillance monitoring -Data collection, along with record keeping -Monitoring staff compliance with infection control practices Residents #5 and #39 had appropriate precautions implemented. The facility staff received education on the proper infection control practices including but not limited to: -Proper hand hygiene -Shower disinfectant procedure	4/23/12
F 441 S9=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 18 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 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.	F 441	-Proper urinary catheter bag placement -Types of isolation precautions -PPE equipment use and location -Appropriate utilization of gloves **Identification of Others:** The lab log was audited for cultures obtained and investigated for follow up on any precautions or therapeutic actions necessary. Residents currently on or placed on the Infection Control Log after 3/1/2012 were checked for culture results and evidence of clinical resolution if antibiotic regimen was completed. The log was updated as needed. **Systemic Changes:** The LN staff will notify the attending physician after assessing a resident and have identified this resident to be at risk for infection. Physician ordered laboratory results are written on the 24 Hour Change of Condition Report and obtained in a timely manner. Laboratory tests are documented on the lab log when obtained and are sent out to the lab. Physicians are notified of the laboratory results when they are obtained by the lab. The LN is to contact the physician if no response is obtained within 4 – 6 hours (physicians are notified immediately for critical lab results) for those labs	

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	535038	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 10TH STREET RAWLINS, WY 82301

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F 441	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection surveillance activities, medical records, and product label information, the facility failed to accurately and completely document surveillance data for 8 of 24 residents monitored for infections over the last two months. The facility further failed to identify 2 sample residents (#5, #39) with epidemiologically significant bacterial culture isolates. In addition, the facility failed to implement a systematic program for monitoring staff compliance with infection control practices. The findings were: 1. Infection surveillance records were reviewed on 2/29/12 at 3:10 PM; the sample consisted of resident infections monitored in January and February 2012. These documents revealed inconsistent and incomplete data collection; six resident infection entries logged in January 2012 lacked evidence of clinical resolution. Further, records for February 2012 failed to include culture results for two residents. The medical records for these last two residents were reviewed on 2/29/12 at 4:15 PM and found to contain laboratory reports dated 2/24/12; each resident was reported to have both MRSA and Escherichia coli (E coli) isolated from wounds. The infection control nurse (ICN) stated in interview on 2/29/12 at 4:30 PM that she was new to the ICN position and had received limited training in surveillance techniques. She confirmed infections were not uniformly tracked to clinical resolution. She stated she did not always receive microbiology culture results before the reports were filed in resident medical charts. The ICN	F 441	requiring actions. The LN staff documents each completed step on the laboratory log. Precautions for any positive laboratory tests which are infections are placed into effect and staff notified of the precautions. The IC Nurse is notified of the results and the precautions. Physician orders are obtained for treatment and the medication is obtained and administered in a timely manner. The physician will be notified if the treatment is not available timely for any changes. The laboratory results report will be placed in the resident's medical record. **Monitoring:** The SDC/Designee will conduct rounds to monitor for presence and use of appropriate infection control precautions. This will be done 3-5 times a week for four weeks and then will be re-evaluated. Based on the results of the rounds, corrective action will be taken and additional training provided to staff as needed. The SDC/Designee will observe the disinfecting of the shower/bath rooms 3-5 times per week for four weeks to determine if staff is waiting an adequate amount of time, based on the	

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F 441	Continued From page 20 further stated laboratory reports, to include culture results, were not systematically monitored, resulting in surveillance data being missed. She acknowledged information confirming MRSA culture results for residents #5 and #39 was not reported to her and, as a result, facility staff failed to identify, and act on, these epidemiologically significant findings. The ICN acknowledged significant culture findings, such as MRSA from an active infection, would require staff to follow transmission-based precautions when providing care to the residents. 2. Multiple observations on 2/28/12 and 2/29/12 showed the facility failed to identify, evaluate, and implement precautions for residents #5 and #39 who were currently residing in the facility with MRSA. The following discrepancies were noted: a. Review of a 2/21/12 laboratory report for resident #5 showed a wound culture was requested on his/her pressure ulcer. A culture and sensitivity report dated 2/24/12 showed the laboratory isolated MRSA and E. Coli from the wound. Observation on 2/28/12 at 9:55 AM showed CNA #8 checked the resident for fecal incontinence by looking under his/her incontinence brief without first donning gloves. The CNA found the resident was incontinent of feces. She then put on gloves to change the resident's incontinence brief without first washing her hands. While the CNA was turning the resident side-to-side, her clothing came in direct contact with the resident's bed linens. An interview with the CNA immediately following the observation revealed she was not aware the resident had a wound infection. At the time of the observation, there was no personal protective equipment immediately available for use.	F 441	manufacturer's instructions, before rinsing. Based on the results of the observations, corrective actions will be taken and additional training will be provided to staff as needed. The SDC/Designee will conduct rounds 3-5 times per week for four weeks to determine if catheter bags are positioned properly. Based on the results of the rounds, corrective action will be taken and additional training will be provided to staff as needed. The SDC/Designee will observe hand hygiene compliance for all staff 3-5 times per week for four weeks and then re-evaluate. Based on the results of the observations, corrective actions will be taken and additional training will be provided to staff as needed. The DNS/Designee will monitor the infection control logs weekly and the physician orders 3 – 4 times per week for compliance with the facility's infection control policy and procedure. The results of the rounds and observations will be reported to the PI Committee for review and further recommendations. The PI Committee will determine the frequency of ongoing monitoring. The DNS/Designee will monitor the lab log 3-4 times a week for completeness, timeliness and accuracy of labs, results,	

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F 441	Continued From page 21 b. Review of resident #39's medical record on 2/29/12 at 11:22 AM showed s/he had positive culture results for both MRSA and E. coli isolates from a wound. The culture results were dated 2/24/12. Interview with LPN #6, on 2/29/12 at 2:30 PM, revealed she was unsure what bacteria were isolated from the resident's wound. The LPN thought it was "....E. coli and maybe something else, too..." The ICN stated in interview on 2/29/12 at 4:45 PM she was not aware the resident had a MRSA isolate recovered from the wound. Interview with the manager of the reporting laboratory on 2/29/12 at 4:15 PM confirmed the culture reports were faxed to the facility on 2/24/12. 3. Review of facility infection control policies and procedures on 2/29/12 at 9:35 AM revealed a requirement for process surveillance activities, such as monitoring staff compliance with infection control practices. The ICN stated in interview on 2/29/12 at 2:05 PM that she observed staff to ensure they knew the correct steps for washing their hands. She acknowledged, however, that she did not monitor opportunities for hand hygiene among staff nor did she monitor the overall compliance rate for hand hygiene at the facility. The ICN further stated she was not aware of any ongoing programs to monitor non-nursing staff for compliance with infection control practices. 4. Interview with CNA #5 on 2/29/12 at 3:33 PM established she was one of the CNAs responsible for resident showers and cleaning the shower room between each use. She stated she used a spray-on disinfectant solution to clean the walls, floor, and shower chair. The CNA further stated	F 441	and therapeutic treatments. The DNS/Designee will audit charts of residents with completed labs for placement of the lab report in the residents MR. The results will be reported to the PI committee for review and further recommendations. F-496 NURSE AIDE REGISTRY VERIFICATION RETAINING Corrective Action: The nurse aide registry has been checked for any findings of abuse, neglect, mistreatment of residents, or misappropriation of resident property for CNAs #1, 2 and 3. There were no reports filed. The SDC was educated on the nurse aide registry and the requirement for use. The	4/13/12

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F 441	Continued From page 22 she allowed the disinfectant to remain on environmental surfaces for "...three or four minutes..." before rinsing the disinfectant off with water. Review of the product label information on the disinfectant showed it required a minimum of 10 minutes of wet exposure to effectively disinfect common environmental surfaces. The CNA stated she did not know about the exposure time required for the disinfectant and thought the procedure she followed was sufficient to disinfect the shower room and associated equipment. The environmental services manager stated in interview on 3/1/12 at 9:45 AM that he did not routinely monitor housekeeping or laundry staff for hand hygiene compliance. He further acknowledged his staff prepared the disinfectant solution for use in the tub and shower rooms; he was not aware the product required a ten-minute exposure time for effective disinfection. Observation on 2/29/12 at 9:40 AM showed resident # 2 had his/ her uncovered foley catheter bag on the floor of his/her room. Interview with CNA #10 on 3/1/12 at 9 AM revealed foley catheter bags were not to be placed on the floor. Further, proper placement was necessary to prevent "UTIs "[urinary tract infections]. Review of the facility policy for "Indwelling Urinary Catheter Care," PRO 66201-03, showed, "Do not rest the bag on the floor." The ICN stated in interview on 3/1/12 at 10:10 AM she did not routinely monitor cleaning and disinfecting of the tub and shower rooms, nor did she monitor catheter care. The ICN stated she relied on other nursing staff to train CNAs on disinfection procedures and foley catheter care.	F 441	need to check the nurse aide registry prior to hiring nurse aides has been added to the nurse aide orientation checklist. Identification of Others: The nurse aide registry has been checked for all nurse aides currently working in the facility by the SDC. There were no reports filed. Systemic Changes: The SDC/designee will check the nurse aide registry for nurse aide applicants for any findings of abuse, neglect, mistreatment of resident, or misappropriation of resident property prior to the nurse aide's hiring. Monitoring: The Payroll/Benefits Coordinator (PBC) will audit the newly hired nurse aides file for compliance. Concerns will be reported to the DNS for immediate corrective action. The results of the audits will be reported to the PI Committee monthly for further review and evaluated for corrective actions until resolved.	

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F 441	Continued From page 23 She further stated her expectation that the training be accurate and complete.	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 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:	F 496		

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F 496	Continued From page 24 Based on staff interview, employee record review, and review of policy and procedure, the facility failed to ensure the nurse aide registry was checked for 3 of 3 CNAs (#1, #2, #3) whose records were reviewed. The findings were: Review of the facility policy and procedure "POL 504-01" dated 2/28/06 on abuse compliance guidelines showed, "...9. Investigations into the past histories of a potential employee include: a. Inquiry of the state nurse aide registry or licensing authority..." The following concerns were noted when CNA employee files were reviewed: a. Review of the employee file for CNA #1 showed a date of hire on 1/31/12. The file showed background screening; however, there was no evidence the state nurse aide registry was checked for any findings of abuse. b. Review of the employee file for CNA #2 showed a hire date of 1/13/12 with no evidence the nurse aide registry was checked. c. Review of the file for CNA #3 showed a hire date of 12/31/11 with no evidence the nurse aide registry was checked. During an interview on 3/1/12 at 10:04 AM, RN #7 stated she had been in charge of the employee files since November 2011; however, she was not aware of the nurse aide abuse registry. At that time, she verified the nurse aide abuse registry had not been checked for any CNAs in the facility.	F 496	F-502 ADMINISTRATION Corrective Action: The physician for resident #39 was notified of the BMP results on 2/29/12. No new orders were received. Resident #18's physician was notified of the laboratory results. No new orders were received. Resident #1's physician was notified of a urine dipstick test performed on 2/15/12 and that the results were unknown. No new orders were received. The LN staff has been educated on the facility policy and procedure regarding the acquisition, delivery, and follow up of physician ordered laboratory tests and timely notification of the physician of results.	4/23/12
F 502 SS=E	483.75(l)(1) ADMINISTRATION 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.	F 502	Identification of Others: Physician orders and the Lab Log was reviewed for labs ordered but not completed timely and/or follow up completed when necessary. The MR of residents with recent labs on the Lab Log	

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F 602	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to perform laboratory testing as ordered for 3 of 12 sample residents (#1, #18, #39). In addition, the facility failed to ensure the results were available for physician review in a timely manner. The findings were: 1. Review of orders for resident #39 showed that on 2/14/12 the physician ordered a BMP (basic metabolic panel) to be done on 2/18/12. Detailed review showed the results were not in the medical record on 2/28/12. Further investigation revealed the performing laboratory did not collect the specimen until 2/22/12 and faxed the results to the facility on 2/23/12. The facility did not provide an explanation as to why the test was not performed on 2/18/12 as ordered, nor why the results had not yet been reviewed by the ordering physician five days after they were received. 2. Review of laboratory results for resident #16 dated 1/8/12 showed the physician had ordered culture and sensitivity tests of the resident's urine and started the resident on an antibiotic. Review of the culture results dated 1/10/12 showed "Mixed bacteria isolated. Possible contamination with normal urogenital flora. Recollect if clinically indicated." The sensitivity test was not done. On 2/29/12 at 3:23 PM RN #12 stated they did not re-collect the urine specimen to perform the sensitivity test to determine if the antibiotic was appropriate. Further, there was no evidence the physician was ever notified of the preliminary results. 3. Review of the nurses' notes for resident #1,	F 602	was reviewed for the lab report and documentation of any actions or physicians orders. Systemic Measures: The LN staff will notify the attending physician after assessing a resident and have identified this resident to be at risk for infection. Physician ordered laboratory results are written on the 24 Hour Change of Condition Report and obtained in a timely manner. Laboratory tests are documented on the lab log when obtained and are sent out to the lab. Physicians are notified of the laboratory results when they are obtained by the lab. The LN contacts the physician if no response is obtained within 4 – 6 hours (physicians are notified immediately for critical lab results) for those labs requiring actions. The LN staff documents each completed step on the laboratory log. Physician orders are obtained for treatment and the medication is obtained and administered in a timely manner. The physician will be notified if the treatment is not available timely for any changes. The laboratory results report will be placed in the resident's medical record.	

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F 502	Continued From page 26 dated 2/16/12 at 11:40 PM, showed the resident had complaints of an urge to void but was unable to produce much urine. The note further showed a urine dipstick test was performed and the results faxed to the physician. Review of the record failed to show the results of the urine test. Interview with LPN #6 on 3/1/12 at 9:26 AM revealed a fax to the physician was not found and confirmed the results of the urine dipstick test were not in the record. The results of the dipstick test were unknown.	F 502	Education is provided to nurses upon hire and as needed related to the facility policy and procedure related to laboratory testing. Monitoring: The DNS/designee will review physician orders, the 24 hour Change of Condition Report and the Lab Log for laboratory tests and audit for results, and physician notification. Based on this audit, corrective action, including additional training for nurses, will be done. This will be done weekly for four weeks and then re-evaluated. The DNS/designee will report the results of the audits to the PI Committee monthly for further review and evaluation for further corrective action until resolved. F-503 LAB SVCS-FAC PROVIDED REFERRED AGREEMENT Corrective Action: The undated test solutions for the Sure Step glucose monitors in the front and back nurse's stations were disposed of per facility policy. The LN staff was educated on the Sure Step Pro manufacturer's instructions on control solutions. Identification of Others: An audit of both SureStep Pro cases was	4/25/12
F 503 98=F	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.	F 503		

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F 603	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's instructions, the facility failed to follow the manufacturer's requirements for the use of 2 of 2 glucometers. This failure affected all residents receiving routine glucose testing. The findings were: 1. Observation on 2/29/12 at 4:20 PM showed a glucometer with the Sure Step glucose control solutions, used for quality control testing, was located on the medication cart at the front nurses' station. The low and normal test solutions were not labeled with the date they were opened. Interview with LPN #6 at that time confirmed the solutions were not dated when they were opened and they were available for use. 2. Observation on 2/29/12 at 4:40 PM showed a glucometer with the Sure Step glucose control solutions was located on the medication cart at the back nurses' station. The normal test solution was not labeled with the date it was opened. Interview with RN #12 at that time confirmed the solution was not dated when it was opened and it was available for use. 3. Review of the manufacturer's instructions printed on each of the Sure Step Pro glucose control solution bottles showed "Discard 90 days after opening." In addition, the label included an area to write the date the solution was opened; however, the space was left blank.	F 603	completed and none were found to be non-compliant. **Systemic Changes:** All multiple dose vials are to be labeled with permanent marker the date in which they are opened by the LN. They are disposed of according to the manufactures instructions. During the evening shift the incoming and outgoing LN will check all multiple dose vials in the medication cart, refrigerator, and glucometer case for compliance with the policy and initial upon completion. Any noncompliant vials will be given to the SDC/Designee and corrective actions taken. **Monitoring:** The DNS/Designee will monitor the Sure Step Pro control solutions weekly for compliance with the manufacturer's instructions. Immediate corrective actions will be taken for non-compliance. This will be done weekly for four weeks and then re-evaluated. The results of the audits will be presented to the PI Committee monthly for review and evaluation for corrective actions until resolved.	4/25/12
F 607 SS=D	483.75(l)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical	F 607	F-507 LAB REPORTS IN RECORD-LAB NAME/ADDRESS	

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F 607	Continued From page 28 record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory results were filed in the medical record for 2 of 12 sample residents (#5, #39). The findings were: 1. Review of orders for resident #39 showed the physician ordered a BMP (basic metabolic panel) to be done on 2/18/12. Detailed review showed the results were not in the medical record on 2/28/12. On 3/1/12 at 12:52 PM, RN #7 confirmed the results were not filed in the resident's medical record. 2. Review of the laboratory report for resident #5 showed s/he had a wound culture from a pressure ulcer that was collected on 2/21/12. The preliminary report dated 2/22/12 showed the culture was positive for a pathogenic organism, but the sensitivity test was not yet completed. Review of the laboratory report dated 2/24/12 showed the results of the sensitivity test listed the organism as resistant to oxacillin, indicating the wound was positive for MRSA. Further review showed the facility failed to file a complete report as only the second page of the final report was in the medical record. Interview with LPN #8 on 2/28/12 at 9:40 AM revealed she was unaware the resident had a MRSA positive culture report. Further, the LPN was unable to find the first page of the 2-page laboratory report regarding the culture findings. After obtaining the entire report,	F 607	**Corrective Action:** Residents #30 and #5 have had the complete laboratory report placed in their medical record. The LN staff had been educated on the facility policy and procedure regarding the acquisition, delivery, filing of reports and follow up of physician ordered laboratory tests. **Identification of Others:** The lab log and physicians orders for laboratory tests were reviewed to determine if results for ordered tests were in the record. Based on the results of the audit, lab results were placed in the record as needed and additional training was done for nurses as needed. The lab log will be used as a tracking method for the filing of lab reports b **Systemic Changes:** The LN staff will notify the attending physician after assessing a resident and have identified this resident to be at risk for infection. Physician ordered laboratory results are written on the 24 Hour Change of Condition Report and obtained in a timely manner. Laboratory tests are documented on the lab log when obtained and are sent out to the lab. Physicians are notified of the laboratory results when they are obtained by the lab. The LN contacts the physician if no	

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	836030	A. BUILDING _____ B. WING _____	03/01/2012

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F 607	Continued From page 29 the results showed the definitive diagnosis of MRSA. Interview with the manager of the laboratory performing the culture on 2/29/12 at 3:10 PM confirmed the resident's culture findings and revealed both pages of the report were faxed to the facility on 2/24/12.	F 607	response is obtained in a reasonable amount of time for those labs requiring actions. Precautions for any positive laboratory tests which are infections are placed into effect and staff notified of the precautions. The IC Nurse is notified of the results and the precautions.	
F 620 S8=P	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 620	Physician orders are obtained for treatment and the medication is obtained and administered in a timely manner. The physician will be notified if the treatment is not available timely for any changes. The laboratory results report will be placed in the resident's medical record Monitoring: The DNS/designee will review physician orders, 24 Hour Change of Condition Report and the Lab Log for laboratory tests and review the resident's MR for the filing of the lab report. Based on this audit, corrective action, including additional training for nurses, will be done. This will be done weekly for four weeks and then re-evaluated. The DNS/designee will report the results of the audits to the PI Committee for further review and evaluation for corrective action until resolved.	

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F 520	Continued From page 30 Based on staff interview and review of the QAPI program, the facility failed to ensure physician attendance at 1 of 4 quarterly meetings during this past year. In addition, the facility failed to identify pertinent issues, develop and implement appropriate interventions to resolve those issues, and establish a program that enabled sustained compliance with previously identified issues. The findings were: 1. During an interview on 3/1/12 at 9:16 AM, the administrator stated the facility held monthly QAPI meetings. However, he identified the quarterly meetings as occurring in January, April, July, and October. Review of the QAPI attendance rosters showed a physician was not in attendance at the quarterly meeting in October 2011. At that time, the administrator confirmed lack of evidence of physician attendance at the meeting. 2. Review of the QAPI program showed the facility failed to identify, resolve, and/or maintain compliance with the following pertinent issues: a. Issues with the facility's infection control program were cited during the previous three surveys in 2009, February of 2010, and August of 2010. In addition, infection control issues were cited during the complaint survey of 12/22/11. A plan of correction was developed and monitored through the QAPI program, but the facility was unable to sustain compliance. Multiple issues related to infection control practices were again cited during the current survey (F441). b. Prior to a complaint survey conducted on 12/22/11, the facility identified an issue involving incorrect administration of medications. The facility implemented a plan of action to correct the problem. However, incorrect medication	F 520	F-520 COMMITTEE-MEMBERS/MEET QUARTERLY /PLANS Education was provided to the Medical Director by the ED regarding the requirements for attending quarterly PI Committee meetings. The incorrect OTC medication was removed from the nurse's cart. The LN staff had been educated on the following: -The facility policy on multiple dose medication labeling -Adherence to the manufacturer's information sheet - The facility policy and procedure for medication administration including OTC medications The SDC has been educated on the proper method of medication administration auditing. Identification of Others: An audit of the last week's physicians' orders was completed and there are currently no residents with physician ordered medications that are unavailable for administration in a timely manner. An audit of physician ordered over-the-counter (OTC) medications was done to determine if they matched the OTC medication label. Based on results of the	4/23/12

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F 520	Continued From page 31 administration related to unavailability of medications was rewritten during the 12/22/11 survey. The facility developed and implemented a corrective action plan monitored through the QAPI program but was unable to maintain substantial compliance. Issues related to availability of medications were cited during the current survey (F426). c. Other deficiencies of significant concern included two in quality of care at F309 (cited in 2/2010 and the complaint survey of 12/22/2011) and F315, one in physician services (F367), cited in 2009 and 2/2010, and three in laboratory services (F502, F503, F607).	F 520	audit, corrective actions were taken and additional training was provided to nurses if needed. **Systemic Changes:** LN staff compare any ~~OTC~~ medications to be administered to the residents MAR and the physicians order for accuracy when received from the pharmacy vendor and prior to administration. **Monitoring:** The SDC/Designee will audit five medication administrations per week for four weeks and then will re-evaluate. Based on the results of the observations, additional training will be done with the nurses as needed. The SDC/Designee will audit ten MARs per week for four weeks to determine if physician ordered medications matching the medication label. Unmatched medications will be disposed of per facility policy and immediate corrective actions will be taken. The results of the observations and audits will be reported to the ~~Medical Director~~ District Director of Operations during the monthly PI meeting for review and evaluation for corrective actions.	