RECEIVED
WY Dept of Health
JUL 17 2012
Healthcare Licensing and Surveys

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

PRINTED: 07/06/2012
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
	535022	A. BUILDING ______ B. WING ______	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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	F 000		07/27/12

F 000 INITIAL COMMENTS

The following common abbreviations are used throughout this document:

ADL- activities of daily living
CAA- Care Area Assessment
CDM- certified dietary manager
CNA- certified nursing assistant
DON- director of nursing
LPN- licensed practical nurse
MAR- medication administration record
MDS- Minimum Data Set
mg- milligrams
PT- physical therapist
RN- registered nurse
RD- registered dietitian

Less commonly used abbreviations will be annotated in each deficiency where used.

F 174 SS=B 483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY

The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

This REQUIREMENT is not met as evidenced by:
Based on observation and interviews with residents and staff, the facility failed ensure effective measures were utilized by the laundry service to safeguard personal clothing for 6 of 13 residents who attended the group meeting. The findings were:

During a confidential meeting on 6/19/12 at 3 PM, six of thirteen residents stated they were recently seeing an increase in lost clothing in the laundry

F 174

F174 The resident has the right to have unlimited use of telephone without being overheard. (laundry) The facility will ensure this will occur by

- On 7/4/12 laundry staff sorted through the two "lost clothing bins" and identified some items as belonging to residents and began to label donated items as "donated".
- All environmental service and laundry staff have been educated on the labeling process at Pioneer Manor. 07/05/12

All residents have the potential to be affected by lost clothing

Systemic process;

- No-name clothing bin(s) will be brought to the resident care areas three times per week to allow residents/families/staff to identify clothing.
- A new clothing labeling process is being implemented with the goal of having personal clothing/belongings labeled and returned to the resident within 24 hours.
- Letters will be sent to all current residents/families with information regarding facility laundry practices and schedules. This information will also be provided to all new admissions.
- A laundry staff representative will attend the facility new staff orientation to provide education on the resident laundry practices.
- The Resident Council will be asked if a representative from laundry can attend a portion of the RC meetings to address laundry issues/concerns.
- All new resident laundry will be placed in color coded bags and sent to laundry with a reconciliation sheet for labeling.
- The color coded bags will also be available to resident/families pre-admission.
- Environmental service staff will be responsible for delivering resident laundry.
- All staff will be educated on the use of the current "Concern/Issue form to report missing clothing. All concern/issue forms are to be turned in to Social Services and disseminated as appropriate. Policy review and revision.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 7/13/12

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.

This POC agreed to with agreed to changes between the administrator (Brittle Bilodeau) and Tony Mottley, surveyor on 7/18/12 the POC d. 7/27/12. 7/18/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 174	Continued From page 1 department. Interview with laundry supervisor #1 on 6/20/12 at 10:48 AM revealed the following information: The facility policy was to minimize lost clothing by encouraging residents to allow laundry staff to stamp their clothing with an identification label upon admission and whenever they received new clothing items. Items with faded labels or no labels were placed in a "lost clothing" bin, and laundry staff were to attempt to identify the owner by remembering what each resident wore. The laundry was no longer being done at the nursing home, but rather by the laundry department at the hospital. The hospital laundry staff were unfamiliar with nursing home residents. Therefore, there was an increase in unlabeled clothing being placed in the "lost clothing" bin. In the past three months the amount of lost clothing had increased and currently there were two full "lost clothing" bins. Observation on 6/20/12 at 10:48 AM confirmed the two bins were full of unlabeled clothing that belonged to residents.	F 174	Outcome: 100% of concerns related to resident laundry will be documented. Social Services will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assess 1 of 20 sample residents (#63) reviewed for self-administration of medications. The findings were:	F 176	F176 The resident may self administer drugs if the interdisciplinary team has determined this practice is safe The facility will ensure this will occur by Resident# 63 • Resident assessment/evaluation for self administration of medications • Documentation on care plan of self administration of medications • Staff education regarding documentation of self administered medications • Policy was in place, not provided to surveyor due to miscommunication	07/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	500 W 8TH ST GILLETTE, WY 82716

(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 176	Continued From page 2 Observation on 6/20/12 at 3:15 PM revealed resident #63 showed the surveyor the medications in his/her room and stated s/he was responsible for self-medication administration. At that time the observed medications included Neomycin/Polymyxin B Sulfate Hydrocortisone Otic, and Tincture of Benzoin. Review of the medical record showed no evidence an assessment for self-administration of medications was performed. During an interview on 6/21/12 at 2:45 PM, unit manager #1 confirmed the assessment had not been done. At that time, the surveyor requested the policy and procedure for self- medication administration, but none was provided.	F 176	F176 *continued* **Identification of other residents will occur by:** Other residents that are currently self administering medications Chart audit to determine if any other residents are currently self administering medications. Perform medication self administration assessment/evaluation on all residents identified with self administration of medications **Systemic process:** • Staff education regarding assessment/evaluation related to self administration of medications and documentation • Review/ revise policy "Medication self administration" • Review and revise assessment/evaluation form and MAR • Medication self administration quarterly, significant change and annual review. **Outcome:** 100% of residents who self administer medications will demonstrate competency DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	
F 241 SS=D	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 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, interviews with family, resident, and staff; review of policies and procedures; and medical record review, the facility failed to ensure staff supported the dignity of 3 of 20 sample residents (#30, #57, #63). The findings were: 1. Observation on 6/18/12 from 4:50 PM until 6 PM revealed resident #63 was sitting in a chair in his/her room and a container of urine was positioned on the floor beside the chair visible to	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 241	Continued From page 3 everyone who passed the opened door. During an interview on 6/19/12 at 10:15 AM the resident stated "it bothers me" when staff did not promptly empty the urine filled container. The resident further stated it was visible to everyone who passed his/her room, and sometimes s/he was concerned the container might overflow. Review of the 4/18/12 quarterly MDS assessment showed the resident had limited physical ability and did not have cognitive impairment. According to the care plan, updated 6/12/12, staff were responsible for emptying the urine container. 2. Review of the 4/4/12 quarterly MDS assessment for resident #30 showed s/he required assistance with all ADLs, including toileting and transfers to and from the wheelchair. According to the care plan the resident was unable to verbalize his/her needs due to a stroke, but was able to communicate effectively with gestures. Observation on 6/19/12 at 12:05 PM revealed CNAs #3 and #4 assisted the resident to the bathroom. During this time the roommate's visitor, who was the opposite sex, remained in the room seated approximately five feet from the curtain that enclosed the bathroom. Interview with resident #30's family member on 6/21/12 at 1:40 PM revealed the visitor's presence in the room caused discomfort and anxiety for the resident. 3. Observation on 6/20/12 at 3:50 PM showed resident #57 had a visible uncovered urine collection bag attached under his/her wheelchair. At that time the resident was in the common area watching the afternoon entertainment with other residents. Interview with LPN #1 on 6/20/12 at 4:15 PM revealed the urine bag needed to be covered while the resident was outside his/her	F 241	**F 241 Promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality** The facility will ensure this by: Resident #63 • A small trashcan was provided for resident to place his urinal in for dignity provisions. 06/22/12 • Careplan was updated on 6/22/12 regarding the use of the trashcan, to provide frequent checks to empty urinal. • Education was provided to resident on use of his call light to call for assistance when he wants his urinal emptied.06/22/12 Resident #30, • Resident and her spouse were educated on the need to provide privacy to her roommate when staff are assisting the roommate with personal cares. • They agreed to have visitors step out of the room when asked by staff. 06/22/12 • Careplan was updated and on the spot education was completed with several nursing staff across two shifts.06/22/12 Resident #57 • A catheter bag cover was placed over the exposed drainage bag. 06/20/12 **Identification of other residents will occur by:** • All residents who use urinals for bladder elimination have the potential to be affected. • All residents who have roommates have the potential to be affected. • All residents who have a catheter have the potential to be affected.	07/27/12

8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

(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 241	Continued From page 4 room. Review of the policy and procedure for Urinary Catheter Care, last revised March 2012, showed: "Use a catheter cover bag for resident dignity."	F 241	F 241 continued Systemic process: • All staff will receive education on identifying and promoting resident dignity within the facility. • On the spot education will be provided as needed when dignity issues are identified.	
F 248 SS=B	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of resident council meeting minutes, the facility failed to ensure residents' requests for additional activity choices were addressed for 7 of 13 residents in the group meeting. The findings were: During a confidential meeting on 6/19/12 at 3 PM, seven of thirteen residents stated they would like to have more activity options from which to choose. They also stated the issue was discussed at the resident council meetings. Review of the previous three months resident council meeting minutes revealed very little discussion was held regarding the actual current activities program, and the issue of adding more activities was not mentioned. Interview with two activities staff members (#1 and #2) on 6/20/12 at 10:48 AM revealed activities staff were aware of the residents' desire to have more activity choices, but they had not addressed this concern.	F 248	Outcome: 100% of residents will have privacy and dignity upheld in regards to toileting and elimination. DON or designee will collect data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	
F 250	483.15(g)(1) PROVISION OF MEDICALLY	F 250		

4/17/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 250 SS=D	Continued From page 5 RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide medically-related social services to assist staff in developing, implementing, and revising a consistent, unified method of addressing the behaviors of 1 of 21 sample residents (#19). The findings were: Observation during an interview with resident #19 on 6/18/12 at 5:38 PM showed an unidentified CNA brought in the evening meal, asked the resident if s/he would like mustard, brought it as requested, and then left. The CNA did not make any other comment or respond to the resident's sarcastic comments about the dietary staff. During the interview, the resident's comments remained hostile and sarcastic, and his/her demeanor ranged from anger to tears. The resident expressed many complaints about the dietary department, inappropriate diet, staff checking the temperature of a personal refrigerator, staff not knocking and identifying themselves, and an alleged assault. An additional observation on 6/19/12 at 11:28 AM showed another CNA also just set the resident's meal tray down and left after nothing else was requested; there was no other interaction between the	F 250	**F 248 The facility must provide for an ongoing program of activities designed to meet in accordance with the comprehensive assessment, the interest and the physical, mental and psychosocial well being of each resident** The facility will ensure this will occur by: • Standard agenda developed to include but not limited to food, activities, safety concerns, response to concerns, laundry, Resident rights, new processes and policies. • Development of minutes system and staff education • Staff education related to concern/issue form for use in communication of resident **Identification of other residents will occur by:** All residents have the potential to be affected by quality of life and activities **Systemic process:** • All issues/concerns will be reported to Quality committee monthly with resolution documented • All concern/issue review forms will be sent to Social Services and disseminated as appropriate • Issues related to concerns will be addressed by specific department • Review process for resident council structure	07/27/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 250	Continued From page 6 resident and the staff member. Intermittent observation throughout the survey showed that unless the resident had family visiting, s/he remained in bed with the divider curtain pulled and the lights off. Review of the medical record showed that on 11/9/11 the resident refused the psychological evaluation recommended by the interdisciplinary team and refused to see the psychiatrist on 1/24/12. The psychiatrist was able to visit briefly with the resident's spouse and made recommendations for staff approaches and medication changes. There was no evidence in the medical record that social worker #1 or physician saw the psychiatrist's report. During an interview on 6/20/12 at 11:30 AM, the social worker confirmed she had never seen the report. On 6/21/12 at 10:40 AM, unit manager #1 stated she did not know if the primary care physician (PCP) at that time (no longer the PCP) had seen the psychiatrist's recommendations. She acknowledged physicians usually agreed with medication changes suggested by psychiatrists. Review of the 1/10/12, 3/1/12, and 4/24/12 notes by the current PCP provided no evidence the PCP was aware of the psychiatrist's recommendations. These notes also showed the resident remained hostile, tearful, and sarcastic and displayed no intention of accepting helpful interventions or modifying his/her behavior. Interview with social worker #1 on 6/19/12 at 11:30 AM revealed she was unaware of any attempt to develop and implement a consistent, cohesive plan of approach to be utilized by all staff for addressing the resident's behaviors. On 6/20/12 at 10:45 AM the RD stated she was unaware of a single, consistent approach to be utilized by dietary staff in working with the	F 250	F 248 continued • Review and revise activity evaluation in addition to MDS assessment to include upon admission, readmission, significant change and prn • Policy review and revision specific to activities and Quality committee • Staff education related to minute taking and concern/issue documentation Outcome: 100% of Resident Council minutes will accurately reflect current issues, concerns/recommendations and resolved to satisfaction of residents Social Services will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 250	Continued From page 7 resident. On 6/20/12 at 4:45 PM the social worker confirmed the absence of a unified plan to enable staff to effectively address the behaviors of a resident who displayed difficulty with personal interaction and socialization skills.	F 250	**F 250** Provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. The facility will ensure this will occur by: Resident #19: • Significant change assessment was declared on 6/20/12 with the Overall Plan of Care (OPC) meeting held on 7/3/12. Present at the OPC meeting were facility staff, the resident, the resident's husband, a representative from Wyoming Independent Living and by phone the LTC Ombudsman. • Susan Fisher, PhD has been consulted and will be providing staff education on behavior management/communication strategies for this resident on July 25, 2012. **Identification of other residents will occur by:** All residents have the potential to be affected by medically related social services	07/27/12
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272		

4/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	05/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 272	Continued From page 8 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete comprehensive assessments in a variety of areas for 4 of 23 sample residents (#11, #19, #48, #83). The findings were: 1. Review of the 11/8/11 annual MDS assessment showed resident #11 required extensive to total assistance with all ADLs. However, review of Section V (CAA summary) showed ADLs did not trigger for a comprehensive assessment, and there was no evidence in the record that a comprehensive assessment was conducted. Further review of Section V showed the resident triggered for comprehensive assessments in the areas of delirium and behaviors. Review of that assessment information showed the facility failed to identify the cause, contributing factors, and impact on the resident of each triggered area. On 6/20/12 at 5:05 PM, MDS coordinator #1 stated she was unaware that ADLs had not triggered, and she confirmed comprehensive assessments were not completed in the other itemized areas. 2. According to the 11/2/11 admission MDS assessment, resident #19 required a comprehensive assessment for the area of behavior symptoms. Review of that assessment	F 272	**F250 continued** **Systemic process:** • Review At-Risk meeting structure to address residents with persistent behavioral issues. • Social Service staff will receive copies of schedules for behavioral health consults/appointments monthly and PRN. • Education will be provided to all staff upon hire, annually and PRN regarding accessing and utilizing resident's care plans to be aware of behaviors, preferences and interventions specific to each resident. • Staff reeducation regarding communication of new orders. Outcome: 100% of staff will implement interventions as directed by the behavioral plan. Social services will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535622	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 272	Continued From page 9 information only showed the resident "refused cares" and attempted to "verbally intimidate staff..." The cause, contributing factors, and impact on the resident were not identified. On 6/20/12 at 12:05 PM, MDS coordinator #1 acknowledged the information did not provide a comprehensive assessment. During an interview on 6/21/12 at 9:30 AM, the social worker who completed that assessment stated she did not know the cause of the resident's behavior. 3. Review of the 10/26/11 annual MDS assessment for resident #83 showed delirium was triggered for comprehensive assessment. Further review and interview on 6/20/12 at 1 PM with MDS coordinator #1 revealed the comprehensive assessment had not been developed for the triggered area. 4. Review of the admission MDS assessment dated 1/18/12 showed resident #48 triggered for comprehensive assessments of behavior symptoms and psychosocial wellbeing. Review of the provided information showed comprehensive assessments had not been completed; the facility just reiterated data found in the MDS. 5. According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, "Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions...This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data...Use the	F 272	**F 272 Conduct initially and periodically a comprehensive accurate, standardized reproducible assessment of each residents functional capacity.** The facility will ensure this will occur by: Resident #11 • Handwritten correction of CAA's to include ADL, delirium and behaviors 07/12/12 Resident # 19 • Significant change review to assure behaviors reflected on CAA's 07/12/12 Resident # 83 • Handwritten correction of CAA's to include delirium 07/12/12 Resident #48 • Handwritten correction of CAA's to include behavior and psychosocial wellbeing 07/12/12 **Identification of other residents will occur by:** All residents have the potential to be affected by MDS data entry and assessment **Systemic process:** • Consultant services to be obtained related to MDS accuracy and completion 07/26/2012-07/26/2012	07/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 272	Continued From page 10 information gathered thus far to make a clear issue or problem statement."	F 272	F272 continued • Review and revise process for signatures on MDS • External MDS accuracy audits (10/month) • Staff education related to MDS completion and CAA's documentation Outcome: 100% MDS will be accurate and reflective of resident assessments DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to conduct significant change assessments for 1 of 8 sample residents (#19) who required that type of assessment. The findings were: According to the 11/2/11 admission MDS assessment, resident #19 required limited assistance with walking in the room and in the corridor, bed mobility, dressing, using the toilet, and personal hygiene. In addition, the resident rejected care one to three days per week and had no pressure ulcers. Comparison of that assessment with the 1/17/12 quarterly assessment showed the resident had declined;	F 274		

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 274	Continued From page 11 s/he no longer ambulated, required extensive assistance with dressing and toilet use, and rejected cares daily. Further comparison of the 1/17/12 assessment with the 4/4/12 quarterly assessment showed the resident displayed additional declines; s/he required extensive assistance with bed mobility and personal hygiene and had developed a pressure ulcer first identified on 3/28/12. On 6/20/12 at 12:05 PM, MDS coordinator #1 stated she was unaware of the pressure ulcers; she acknowledged two significant changes should have been completed.	F 274	F 274 Conduct a comprehensive assessment of a resident within 14 days after the facility determines there has been a significant change. The facility will ensure this will occur by: Resident #19, • A significant change MDS was opened due to a decline in ADL abilities and behavioral symptoms, 06/21/12 Identification of other residents will occur by: All residents have the potential to be affected by MDS data entry and assessment and significant changes to their condition	07/27/12
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	Systemic process: • Consultant services to be obtained related to MDS accuracy and completion 07/25-26/2012 • Review and revise process for signatures on MDS • External MDS accuracy audits (10/month) • Staff education related to MDS completion and CAA's documentation • Residents at risk for significant changes are discussed weekly at the facility At-Risk meeting. The At-Risk meeting structure will be evaluated and revised as appropriate. Education will be provided to all staff what constitutes a significant change. Outcome: 100% MDS will be accurate and reflective of resident assessments DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	800 W 8TH ST GILLETTE, WY 82716

(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 278	Continued From page 12 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to accurately assess and complete the assessments for 7 of 20 sample residents (#11, #14, #23, #30, #63, #83, #93). The findings were: 1. Review of the medical record showed the resident was admitted with the colostomy on 1/4/05. Observation on 6/19/12 at 9:36 AM showed resident #11 had a well-healed colostomy. However, review of the the 11/18/11 annual MDS assessment showed the resident was not assessed as having a colostomy. 2. Review of the 4/1/12 significant change MDS assessment for resident #83 showed the resident did not have a bowel movement for seven days. This was verified as an assessment error during interview with MDS coordinator #1 on 6/21/12 at 2:20 PM. 3. Medical record review for resident #93 revealed the admission MDS dated 04/18/12 showed in Section I (Active Diagnoses) that the resident was diagnosed with manic depression as well as depression. Review of the entire medical record revealed no evidence the resident's diagnoses included manic depression. 4. Review of the medical record for resident #23	F 278	F 278 The assessment must accurately reflect the residents status. The facility will ensure this will occur by: **Resident #11** Surveyors identified this assessment as being the 11/18/11 annual. The annual ARD was 10/26/11 and it was marked as having an ostomy. It was the 4/18/12 Quarterly that lacked the ostomy and a correction was done 07/09/12 **Resident #83** • Correction completed 07/09/12 related to no BM for 7 days **Resident #93** • Correction completed 07/11/12 related to diagnosis of manic/depressive **Resident #23** • Correction completed 07/11/12 related to section I not being completed **Resident # 14** • Upon investigation it was determined the section Z on 5/10/12 and 11/23/11 was signed previously **Resident #-63** • Upon investigation Sections V and Z on 10/26/11 was signed previously **Resident # 30** • Correction completed 07/10/12 related to section Z signatures All residents have the potential to be affected by MDS data entry and assessment and significant changes to their condition	07/27/12

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 278	Continued From page 13 revealed his/her admission diagnoses included hyperlipidemia, diabetes and hypothyroidism. However, review of Section I of the admission MDS dated 11/22/11 was blank. 5. Review of the 5/10/12 significant change and 11/23/11 quarterly MDS assessments for resident #14 showed section Z (Assessment Administration) had not been signed. 6. Review of the 10/26/11 annual MDS assessment for resident #63 showed sections V and Z did not include the signatures of staff completing the areas of assessment and care planning. 7. Review of the 10/19/11 significant change MDS for resident #30 showed section Z was not signed. 8. Interview with MDS coordinator #1 on 6/20/12 at 1PM revealed the sections of the MDS assessments were not signed because staff "forgot to do it."	F 278	F278 continued **Systemic process:** • Consultant services to be obtained related to MDS accuracy and completion 07/25-26/2012 • Review and revise process for signatures on MDS • External MDS accuracy audits (10/month) • Staff education related to MDS completion and CAA's documentation **Outcome:** 100% MDS will be accurate and reflective of resident assessments. DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	
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	F 280	**F 280The resident has the right to participate in planning of care and treatment. A comprehensive care plan must be developed within 7 days after comprehensive assessment.** The facility will ensure this will occur by: Resident #19 • Care plan updated to reflect communication and sunglasses 07/03/12 • Care plan updated to reflect skin care 07/12/12 • Significant change assessment was declared on 6/20/12 with the Overall Plan of Care (OPC) meeting held on 7/03/12. Present at the OPC meeting were facility staff, the resident, the resident's husband, a representative from Wyoming Independent Living and by phone the LTC Ombudsman. • Susan Fisher, PhD has been consulted and will be providing staff education on behavior management/communication strategies for this resident on July 25, 2012.	07/27/12

7/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 280	Continued From page 14 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 reviewed and revised the care plans for 4 of 20 sample residents (#19, #48, #57, #87) as each resident's status changed. The findings were: 1. According to the medical record, resident #19 had a diagnosis of macular degeneration and was legally blind. Review of the 4/3/12 care plan for vision, hearing, and communication showed legal blindness and sensitivity to light were listed as visual problems, but staff was instructed to use the white board, an ineffective form of communication for the visually impaired. The same care plan also indicated the resident should wear sunglasses and described him/her as having a "slit in coccyx between upper buttocks." Interventions for the pressure ulcer included the "Wound and Skin Protocol...Calmazine between upper buttocks...Nurse to do visual check after peridare is completed after bms [bowel movements] when possible." In addition, the resident's behavior plan instructed staff to follow the 1/17/12 plan. Observation on 6/18/12 at 5:38 PM showed	F 280	F-280 cont Resident #57 • Care plan revised to reflect transfers, bowel and bladder and IV therapy 07/12/12 Resident #87 • Care plan revised to include specific alternative approaches to pain 07/12/12 Resident #48 • Care plan revised to include antibiotic utilization 07/12/12 **Identification of other residents will occur by:** All residents have the potential to be affected by MDS data entry and assessment and significant changes to their condition	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 280	Continued From page 15 the resident was not wearing sunglasses and actually kept his/her eyes shut. The same observation and conversation with the resident also showed his/her hearing was unimpaired. Staff who entered the room did not use the white board nor remind the resident about wearing sunglasses. All assessments described the resident's hearing as "adequate." Review of the "Wound Protocol," last revised 4/12/12, showed staff could apply Calazime (not Calmazine) as needed to affected areas. It also indicated the nurse or physical therapy was to "assess/evaluate for wound care/needs and notify physician." Interview with wound nurse #1 on 6/20/12 at 10:45 AM revealed she was unaware of the resident's skin issue. She stated she had not been notified of any concerns with this resident's skin, and she confirmed the open area was in a "pressure sore area." The wound nurse confirmed the plan had not been followed and needed to be revised. Review of the 1/17/12 behavior plan, initiated 1/18/12, showed staff expectations of the resident included "1. No refusal of care including medication, treatment and assessments that are directed by her physician or appropriate care provider. 2. No swearing or name calling of the staff or residents. 3. No yelling/shouting or raising of [his/her] voice at staff or residents." The plan continued that if the resident "chooses to engage in any of the above behaviors to the point they inhibit [his/her] plan of care or management of [his/ her] symptoms the facility will...issue a 30-day letter of discharge." Interview with the social worker on 6/20/12 at 11:30 AM revealed the resident's care plan, particularly the behavior plan, needed to be revised. The social worker explained the behavior plan was worded	F 280	**F280 continued** **Systemic process:** • Education will be provided to all staff upon hire, annually and PRN regarding accessing and utilizing resident's care plans to be aware of behaviors, preferences and interventions specific to each resident. • Staff reeducation regarding communication of new orders. • Review At-Risk meeting structure to address residents with persistent behavioral issues. • Social Service staff will receive copies of schedules for behavioral health consults/appointments monthly and PRN. • Staff education related to care planning and CAA's **Outcome: Outcome:** • 100% of staff will implement interventions as directed by the behavioral plan. • 100% care plans will be reflective of resident CAA's and resident assessment/evaluation DON or designee will collect data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

7/17/12 m

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 280	Continued From page 16 incorrectly and that the facility would not discharge the resident, as written, for the itemized concerns. 2. Observation on 6/19/12 at 9:45 AM showed resident #57 was transferred from a raised toilet seat to the wheel chair using a manual lift. In addition, the resident had a brace on his/her right lower extremity that was elevated and secured with Velcro straps to the foot rest of the wheel chair. The following concerns were identified: a. Review of the 5/15/12 care plan for self-care showed the resident was non-weight bearing with ambulation and could transfer with a slide board or sling. In addition, the care plan did not show the resident used a brace or was to have his/her right lower extremity elevated while in the wheel chair. b. The care plan for bowel and bladder showed the resident used a bedpan and not a toilet riser. c. Review of the Interdisciplinary Progress Notes dated 6/14/12 showed the resident's PICC line (peripherally inserted central venous catheter) was discontinued. Review of the 5/15/12 care plan for infection showed; "PICC line care as ordered." 3. Review of the 6/19/12 admission MDS assessment, Section I, for resident #57 showed s/he had diagnoses to include chronic pain syndrome. In addition, Section J showed the resident had occasional pain and his/her worst pain over the last 5 days was 8 on a scale of 0-10 with 10 being the worst. Review of the care plan for pain dated 6/6/12 showed alternative approaches to relief of pain were to be used but did not indicate specifically identify the measures.	F 280	F 281Services provided must meet professional standards of quality. The facility will ensure this will occur by: **Resident #57** • Physician order revised to reflect resident condition and preferences (resident to be up as tolerated and desired) 06/21/12 • Care plan revised 07/11/12 **Resident #12** • 06/21/12 Social services confirmed referral to Dr. Fisher PhD completed, ordered 06/12/12, received order 06/20/12. • Staff did follow physician order, social services unaware of order, reviewed communication process with social service notification of behavioral health consults • Care plan updated 06/21/12	07/27/12

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 280	Continued From page 17 In addition, the resident was to be medicated before his/her procedures and/or treatments; however, the care plan did not specify when the resident was to be medicated; i.e., medicate thirty minutes before treatments. Review of the June treatment flow sheet showed the resident had dressing changes scheduled three times a week. 4. Review of the care plan showed resident #48 was receiving several medications, including Bactrim DS, Clindamycin, Vancomycin, and lactobacillus VSL, for infections. Review of the June 2012 MARs and orders showed the resident no longer received these medications. The care plan had not been revised to reflect the resident's current condition. 5. Interview with the DON on 6/21/12 at 2 PM verified the care plans needed to be updated to show each resident's current status.	F 280	**F 281 continued** **Resident #66** • Immediate on the spot training of Physical Therapy staff regarding hand hygiene, dressing changes, appropriate gloving techniques 06/20/2012, Therapy staff were provided education on 06/26/2012, and 07/11/12. Training completed by both wound certified therapists and infection prevention staff. • Nursing Staff education regarding hand hygiene, dressing changes and appropriate gloving techniques, documentation 07/27/12. **Resident #10** • Immediate on the spot training of Physical Therapy staff regarding hand hygiene, dressing changes, appropriate gloving techniques 06/20/2012, Therapy staff were provided education on 06/26/2012, and 07/11/12. Training completed by both wound certified therapists and infection prevention staff • RoHo cushion in resident closet, cushion replaced in resident chair 06/21/12 • Care plan related to RoHo cushion and wound care verified • Nursing Staff education regarding hand hygiene, dressing changes and appropriate gloving techniques 07/27/12 • Nursing staff education related to PT referrals for screening of seating and cushion needs for residents 07/27/12 • EZ graph with measurements and documentation of assessment completed 06/20/12 • Surgeon referral and appt July 12, 2012	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 staff maintained professional standards of practice related to following physician's orders for 2 of 20 sample residents (#12, #57) and proper dressing change techniques for 2 of 4 sample residents (#10, #66). The findings were:	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 5TH ST GILLETTE, WY 82716

(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 281	Continued From page 18 As related to the failure to follow physician's order: 1. Review of the Provider Consultation Progress Notes dated 6/14/12 for resident #57 showed s/he was "not to be up in chair more than ninety minutes at any one time." Review of the June 2012 treatment flow sheet showed the order was noted but there was no documentation to show the resident was monitored for the length of time s/he was sitting in a chair. Continuous observation on 6/20/12 from 10:30 AM to 2:15 PM (three hours and forty-five minutes) showed the resident sat in his/her wheelchair. During an interview on 6/21/12 at 2:15 PM, the DON stated the nursing staff were expected to follow physician orders or get clarification if the order is questionable. 2. Review of the medical record for resident #12 showed the resident was admitted on 4/12/12 with diagnoses that included failure to thrive, pancreatitis, diabetes, anemia, and major depression. Additional review of the medical record showed that after admission to the facility, the resident was frequently transported back and forth between the facility and the local hospital for acute care. Review of the physician's progress notes and orders showed the physician ordered several acute care procedures as well as a psychological consult on 6/12/12. This review also revealed nursing staff acknowledged the order by writing on the bottom of the physician's note "noted 6/13/12 at 1750." During an interview on 6/20/12 at 9:48 AM, social worker #2 revealed she was unaware of the order for a psychological consult. The social worker also confirmed staff had not obtained the consult in accordance with	F 281	F 281 continued identification of other residents will occur by: All residents have the potential to be affected professional standards of quality **Systemic process:** • Social Service staff will receive copies of schedules for behavioral health consults/appointments monthly and PRN. • Social Services will be notified of any consults for mental health • Referral request form review • Staff education regarding referral request form utilization • Policy review and revision as appropriate • Competency demonstration for therapy and nursing staff (wound care, hand hygiene, aseptic technique) upon hire and annually and as needed. • Policy and procedure review • Staff education regarding aseptic technique, hand hygiene and wound care • Revise wound protocol to include wheelchair cushion screening by rehab services • Wound care protocol revised to include PT assessment per APTA guidelines • Staff education regarding rehab services screening referrals • Staff education regarding compliance with physician orders, clarification of physician orders and interdisciplinary care planning • Develop wound care team to have consistent approach to wound care	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 281	Continued From page 19 the physician's order. 3. According to the Wyoming Nurse Practice Act, revised July 2010, Section 3, pages 3-8 of the Wyoming State Board of Nursing's Administrative Rules and Regulations, nursing staff must function under the direction of a licensed physician. As related to improper wound and pressure ulcer care: 1. On 6/19/12 at 12:25 PM, PT #1 and PT #2 were observed performing dressing changes on the stasis ulcer on resident #66's leg. During the observation, the stasis ulcer was debrided and the vac (vacuum assisted wound closure machine) removed and replaced. Continuous observation revealed the following concerns: a. The clean dressings, sponge, and plastic wound covering dressing were cut with the same pair of scissors that were used to remove the soiled dressings. The scissors were not disinfected or cleaned between the tasks. b. The packaged dressings were opened and placed on a disposable pad positioned under the resident's leg. The contaminated dressings and bloody drainage also had contact with the same disposable pad. c. PT #1 handled the cleanser spray bottle with the same gloved hand that had direct contact with the bleeding wound. d. PT #1 wore two pairs of gloves. She used the outer pair to remove the soiled dressings, and then applied the clean dressings with the second pair without performing hand hygiene. In addition, hand hygiene was not performed until after all of the following tasks were completed: the soiled	F 281	F-281 cont **Outcome:** • 100% of dressing changes will be completed per policy • 100% of staff will demonstrate hand hygiene per policy • 100% of mental health referrals will be communicated to Social Services • 100% of staff will implement interventions as directed by the behavioral plan. • 100% care plans will be reflective of resident CAA's and resident assessment/evaluation DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 281	Continued From page 20 dressings removed and discarded; the wound and bloody drainage cleaned; ointment applied; the vac removed and replaced; and the clean dressings applied. e. Interview on 6/20/12 at 4:20 PM with PT #1 and PT#2 revealed they did not realize the above observations had occurred, and both verified this was not an acceptable standard of practice. 2. PT #1 was observed performing pressure ulcer care and dressing changes for resident #10 on 6/19/12 at 1:10 PM. During the observation PT #1 wore two pairs of gloves. She removed one pair after completing the dressing change on the resident's leg wound, but did not perform hand hygiene prior to using the second pair for removing the dressing that covered the pressure ulcer on the right buttock. When she removed the gauze packing, yellow drainage from the pressure ulcer got on the PT's gloves and disposable pad positioned under the resident. The PT removed the gloves, and again did not perform hand hygiene before she used her ungloved hands to spray the pressure ulcer with the wound cleansing solution. Then she donned a clean pair of gloves and irrigated the area, applied Santyl cream, packing, and dressings. Hand hygiene was not observed until all of the above tasks were completed. Interview on 6/20/12 at 4:20 PM with PT #1 revealed she did not realize the above observations had occurred. At that time PT #1 and PT #2 both verified this was not an acceptable standard of practice. 3. According to the seventh edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2008, wound care must include	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 281	Continued From page 21 regular wound cleansing, the use of semi-occlusive dressings, using standard precautions when providing care, maintaining proper hand hygiene technique, and following dressing change protocols.	F 281		07/27/12
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed the care plan for 1 of 20 sample residents (#10). The findings were: Medical record review for resident #10 showed s/he had a tunneling pressure ulcer on the right buttock. According to the plan of care the resident needed a pressure reducing "RoHo" cushion in the wheelchair. Periodic observations from 6/18/12 to 6/21/12 revealed the cushion in the resident's wheelchair was not the "RoHo". During an interview on 6/21/12 at 2:45 PM nurse manager #1 confirmed the resident did not have the RoHo cushion in the wheelchair. At that time the nurse manager stated it should have been in the wheelchair because the resident needed it.	F 282	**F 282 Services provided or arranged by the facility must be provided by qualified persons in accordance with resident care plan** The facility will ensure this will occur by: Resident #10 • RoHo cushion in resident closet, cushion replaced in resident chair 06/21/12 • Care plan related to RoHo cushion and wound care 06/4/12 verified 06/21/12 **Identification of other residents will occur by:** All residents have the potential to be affected by care by qualified personnel **Systemic process:** • Revise wound protocol to include wheelchair cushion screening by rehab services • Wound protocol education for all staff and PT staff • Develop wound care team to have consistent approach to wound care **Outcome:** • 100% of residents will have seating cushions as indicated by POC • 100% care plans will be reflective of resident CAA's and resident assessment/evaluation • DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	
F 309 SS=E	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	F 309		

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 309	Continued From page 22 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to ensure 1 of 1 sample resident (#66) with non-pressure induced wounds received the necessary care and services to promote healing. In addition, 3 of 8 sample residents (#19, #48, #87) reviewed for pain were not evaluated or re-assessed to determine effective pain management. The findings were: 1. According to the medical record for resident #66, a 5/19/12 physician's order for care of the venous stasis ulcer on the resident's lower leg included the following, "PT for wound care to include debridement of yellow slough, necrotic tissues and vac [vacuum assisted wound closure machine] dressings changes"... every three days. Review of the 5/19/12 documentation by PT showed the wound measured 7.5 (centimeter) cm x 5 cm x 1 cm with bloody drainage, odor, erythma and eschar/slough. This review showed the area measured 6.3 cm x 4.7 cm and continued to have odor, erythema and eschar/slough on 6/13/12. Review of the documentation also showed the dressing and vac changes were completed every three days, however, as of 6/21/12, the PT staff were unable to provide evidence of assessment and	F 309	**F 309 Facility must provide the necessary care and services to attain or maintain highest practicable physical mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care** The facility will ensure this will occur by: Resident #66 • EZ graph measurement of wound performed 06/29/12 • Immediate on the spot training of Physical Therapy staff regarding hand hygiene, dressing changes, appropriate gloving techniques 06/20/2012, Therapy staff were provided education on 06/26/2012, and 07/11/12. Training provided by both wound certified therapists and infection prevention staff Resident #87 • Update care plan to include specific alternative approaches to pain relief done 7/12/12 • Staff education related to following POC Resident #48 • Staff education regarding pain management policy • Updated care plan to include specific alternative approaches to pain relief done 7/12/12 Resident #19 • Staff education related to plan of care • Staff education regarding pain management policy **Identification of other residents will occur by:** All residents have the potential to be affected by pain management practices, care planning and wound care and infection prevention practices	07/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 309	Continued From page 23 measurements of the area after 6/13/12. PT #1 and PT #2 were observed performing dressing changes for resident #66 on 6/19/12 at 12:25 PM. During the observation, the stasis ulcer was debrided and the vac removed and replaced. Continuous observation revealed the following concerns: a. The clean dressings, sponge, and plastic wound covering dressing were cut with the same pair of scissors that were used to remove the soiled dressings. The scissors were not disinfected or cleaned between the tasks. b. The packaged dressings were opened and placed on a disposable pad positioned under the resident's leg. However, the contaminated dressings and bloody drainage also had contact with the same disposable pad. c. PT #1 handled the cleanser spray bottle with the same gloved hand that had direct contact with the bleeding wound. d. PT #1 wore two pairs of gloves. She used the outer pair to remove the soiled dressings, and then applied the clean dressings with the second pair without performing hand hygiene. In addition, hand hygiene was not performed until after all of the following tasks were completed: the soiled dressings removed and discarded; the wound and bloody drainage cleaned; ointment applied; the vac removed and replaced; and the clean dressings applied. e. Interview on 6/20/12 at 4:20 PM with PT #1 and PT#2 revealed they did not realize the above observations had occurred, and both verified this was not an acceptable standard of practice. 2. Review of the facility policy and procedures for	F 309	F309 continued **Systemic process:** • Consistent rehab staffing and communication with nursing staff regarding medication needs prior to treatment • Competency demonstration for therapy and nursing staff (wound care, hand hygiene, aseptic technique) upon hire and annually and as needed • Policy and procedure review • Staff education regarding aseptic technique, hand hygiene and wound care • Staff education regarding pain, assessment/evaluation and reassessment/reevaluation and care planning • Develop wound care team to have consistent approach to wound care • Pain Policy review and revision **Outcome:** • 100% of residents will have pain assessed/reassessed per policy • 100% of staff will demonstrate hand hygiene compliance • 100% of dressing changes will be completed per policy • 100% care plans will be reflective of resident CAA's and resident assessment/evaluation • DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 309	Continued From page 24 wound care, revised 2/8/12, included the following instructions: "Arrange supplies... wash and dry hands thoroughly... position resident... place disposable cloth under wound to serve as a barrier... put gloves on... remove dressings... wash and dry hands thoroughly... put on gloves... use no-touch technique... dress wound according to physician or Physical Therapy orders... discard soiled items and wash hands post procedure." 8. Review of the medical record for resident #87 showed s/he had diagnoses to include osteoporosis and multiple compression fractures. Review of the 6/19/12 admission MDS assessment, Section J showed the resident had occasional pain and stated his/her worst pain over the past five days was 8 on a scale of 0 to 10 with 10 being the worst. Review of the admission orders dated 6/5/12 showed the resident received ibuprofen 600 mg three times daily. In addition, s/he was to receive acetaminophen (Tylenol) 325 mg for pain rated 0 to 4 and 650 mg for pain rated 5 to 10. Review of the 6/6/12 care plan showed the resident was to be medicated for pain before any treatments or procedures. This review also showed alternate approaches to pain relief were to be used, but it did not indicate specifically what methods to use. Review of the June 2012 treatment flow sheet showed the resident received dressing changes three times a week by physical therapy. Review of the pain flow sheet showed the resident only received one Tylenol on 6/9/12 and 6/10/12 for back pain and not for the dressing changes. Interview on 6/21/12 at 10:50 AM with PT #1 stated the resident complained of general pain with movement and during	F 309		

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING: _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 309	Continued From page 25 treatments. During an interview on 6/21/12 at 9:15 AM, CNA #9 stated sometimes the resident complained of pain at bath time, and sometimes the nurses offer pain medications and the resident refused. Review of the June 2012 nursing notes, MARS, and the pain flow sheets showed no evidence that the resident was assessed for pain assessment or evaluation during treatments, activities and bathtime. 4. According to the June 2012 pain flow sheet, resident #48's acceptable level of pain was 3/10 (0-3/10 on a 0 to 10 scale). Further review showed the resident received Percocet frequently for a variety of reasons. However, the effectiveness of the medication was not determined on 6/7, 6/8, 6/10, and 6/11. In addition, if the resident's level of pain had not decreased to 3/10 or less when the effectiveness was re-assessed and there was no evidence other interventions were attempted. On 6/21/12 at 10:40 AM unit manager #1 stated residents were to be re-assessed each time they received a pain medication. She confirmed there was no evidence the re-assessment was performed. 5. Review of the June 2012 pain flow sheet for resident #19 showed his/her acceptable level of pain was 3/10. Further review showed the resident frequently received narcotic and a few non-narcotic medications, usually for pain described as "everywhere" and "chronic." The intensity of the resident's pain was assessed, but there was no evidence a re-assessment was performed to determine the effectiveness of the medications on 6/2 (twice), 6/4, 6/5, 6/8, 6/9	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 309	Continued From page 26 (twice), 6/11, 6/12, 6/16, 6/17, 6/18 (twice), and 6/19 (twice). 6. Review of the facility's policy and procedure, "Pain Evaluation and Management" last revised 2/8/12, showed "Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident..." However, the policy did not address re-assessing the resident's pain level after medication administration. According to the seventh edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2008, recommendations for pain management include: "Assess the effectiveness of pain management."	F 309		
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 observation, medical record review and staff interview, the facility failed to ensure appropriate incontinence care was provided for 1 of 9 residents (#21) observed during the provision of personal care. The findings were: Review of the 6/6/12 significant change MDS for resident #21 showed s/he needed total assistance with toileting and personal hygiene. Observation on 6/19/12 at 9:10 AM showed the	F 312	**F 312 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** The facility will ensure this will occur by: Resident #21 • Remedial training for staff involved initiated June 25,2012 • Annual competency on pericare completed March 2012 **Identification of other residents will occur by:** All incontinent residents have the potential to be affected by incomplete or inappropriate pericare. **Systemic process:** • Pericare competencies completed upon hire, annually and as needed. All CNA's have this competency in their core class • Periodic direct observation to verify compliance with policy and standards **Outcome:** 100% of residents will have pericare performed per policy and standards • DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	07/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 27 resident was incontinent of urine. CNA #4 cleansed the resident's anterior perineum but did not cleanse the entire buttock area and upper thighs where urine had come in contact with the skin. In an interview on 6/21/12 at 2 PM, the DON acknowledged the CNA needed to cleanse all the areas of the resident's skin where it had contact with urine.	F 312	F 314 Facility must ensure a resident who enters the facility without pressure sores does not develop pressure sores and if a resident having pressure sores receives necessary treatment and services. The facility will ensure this will occur by: Resident #10 • Immediate on the spot training of Physical Therapy staff regarding hand hygiene, dressing changes, appropriate gloving techniques 06/20/2012, Therapy staff was provided education on 06/26/2012, and 07/11/12. Training completed by both wound certified therapists and infection prevention staff • RoHo cushion in resident closet, cushion replaced in resident chair 06/21/12 • Care plan related to RoHo cushion and wound care verified • Nursing Staff education regarding hand hygiene, dressing changes and appropriate gloving techniques 07/27/12 • Nursing staff education related to PT referrals for screening of seating and cushion needs for residents 07/27/12 • EZ graph with measurements and documentation of assessment completed 06/21/12 • Surgeon referral and appt July 12, 2012 Resident #57 • On the spot Staff education related to documentation of dressing changes, weekly skin evaluation documentation 06/21/12 • Dressing changes placed on care plan 06/12/12, verified 6/21/12 • Physician order revised to reflect resident condition and preferences (OOB as tolerated, dc order for 90 minutes) 06/21/12	07/27/12
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to ensure monitoring, assessments, and skin care interventions were consistently provided for 3 of 14 sample residents (#10, #19, #57) who were at risk for developing pressure ulcers. This failure resulted in actual harm for one resident (#10) who developed a facility acquired, unstageable, tunneling pressure ulcer. The findings were: 1. Review of the medical record for resident #10 showed staff first noted a blanchable red area on the resident's right buttock on 2/21/12 and a	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 314	Continued From page 28 protective dressing was applied. Further review showed the area did not improve and the resident was admitted to the hospital for intravenous antibiotic therapy from 5/24/12 to 6/2/12. According to the hospital risk management documentation, dated 5/25/12, the pressure ulcer at that time had worsened and was "unstagable", "open", "drained pus" and "tunneling." During an interview on 6/20/12 at 8:15 PM, the DON stated she had identified and addressed the following concerns regarding this resident's care prior to the survey: The nurses did not report the development of the pressure ulcer to the physician until 3/1/12, nor did they follow the wound protocols for treatments and preventive skin care measures. During the months of February, March, April, and May 2012 staff did not perform the dressing changes daily as ordered, and both the nursing and PT staff did not consistently assess, monitor, and document the appearance of the pressure ulcer. Review of the 6/21/12 wound care record showed the pressure ulcer had heavy serosanguinous drainage and measured 0.8 centimeter (cm) in length, 0.3 cm in width and 3.0 cm in depth. In addition there were four undermining areas that measured 3 cm, 2.8 cm, 1.4 cm, and 2 cm. The following concerns were identified during the 6/18/12 to 6/21/12 survey: a. PT #1 was observed performing pressure ulcer care and dressing changes for resident #10 on 6/19/12 at 1:10 PM. During the observation PT #1 wore two pairs of gloves. She removed one pair after completing the dressing change on the resident's leg wound, but did not perform hand hygiene prior to using the second pair for removing the dressing that covered the pressure ulcer on the right buttock. When she removed the	F 314	F 314 continued Resident #19 • Verification that Calmazime was a spelling error on the resident MAR, should have read Calazime , MAR corrected • The bariatric mattress used for Resident #19 is a Direct Supply Panacea Bariatric Mattress verified as a pressure redistribution with super soft heel area 07/12/12. • On 7/12/12 MD notified that areas to buttock resolved and resident requested no more Calazime applied to the area. Care plan updated 7/12/12 **Identification of other residents will occur by:** All residents have the potential to be affected with skin care issues **Systemic process:** • Competency demonstration for therapy and nursing staff (wound care, hand hygiene, aseptic technique) upon hire and annually and as needed • Policy and procedure review • Staff education regarding aseptic technique, hand hygiene and wound care • Revise wound protocol to include wheelchair cushion screening by rehab services • Wound care protocol revised to include PT assessment per APTA guidelines • Staff education regarding rehab services screening referrals • Staff education that all mattresses are pressure reducing mattresses. • Develop wound care team to have consistent approach to wound care • Wound protocol education for all staff and PT staff	

8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 314	Continued From page 29 gauze packing, yellow drainage from the pressure ulcer got on the PT's gloves and disposable pad positioned under the resident. The PT removed the gloves, and again did not perform hand hygiene before she used her ungloved hands to spray the pressure ulcer with the wound cleansing solution. Then she donned a clean pair of gloves and irrigated the area, applied Santyl cream, packing, and dressings. Hand hygiene was not observed until all of the above tasks were completed. b. According to the plan of care the resident needed a pressure reducing "RoHo" cushion in the wheelchair. Periodic observations from 6/18/12 to 6/21/12 revealed the cushion in the resident's wheelchair was not the "RoHo". During an interview on 6/21/12 at 2:45 PM nurse manager #1 confirmed the resident did not have the RoHo cushion in the wheelchair. At that time the nurse manager stated it should have been in the wheelchair because the resident needed it. c. Review of the June 2012 weekly wound care records and nursing notes showed no documentation of the measurements and status of the pressure ulcer from 6/19/12 to 6/21/12. d. During an interview on 6/20/12 at 4:20 PM, PT #1 and PT #2 stated the pressure ulcer continued to worsen because the various treatments were not evaluated for effectiveness in a timely manner to enable more timely consideration for alternative approaches. 2. Observation on 6/20/12 at 8:20 PM showed LPN #2 perform a dressing change for resident #57 on his/her coccyx. Review of the 6/12/12 Hospice Physician Communication Record and Plan of Care Order showed the resident had a stage II pressure ulcer on his/her coccyx. Review	F 314	**F 314 continued** **Outcome:** • 100% of staff will demonstrate hand hygiene compliance • 100% of residents will have seating cushions as indicated by POC • 100% of residents will have documented weekly skin alert/evaluations • 100% of dressing changes will be completed per policy • DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 314	Continued From page 30 of the Interdisciplinary Progress Notes dated 6/12/12 showed a small open area that measured 0.5 by 0.5 cm. Review of the Progress Notes dated 6/19/12 showed the wound measured 0.3 by 0.6 cm and the wound bed was "slightly macerated [softening]", and at that time the wound protocol was to be initiated. The following concerns were identified: a. Review of the treatment flowsheet for May 2012 showed the resident was to have wound care completed each shift and was scheduled three times daily. Further review showed the dressing change was not documented as provided 7 of 27 times. b. Review of the documentation in the May and June 2012 treatment flow sheets for weekly skin assessments showed the resident's skin was only assessed two times in May. Further, the resident was not assessed on 6/5/12, the week before the pressure ulcer was found on 6/12/12. c. Review of the 6/14/12 Provider Consultation Progress Notes showed an order that the resident was not to be up in the chair for more than 90 minutes "at any one time." Review of the June 2012 treatment flowsheet showed the order was noted, but there was no additional documentation to show the length of time the resident was up in the chair. Observation on 6/20/12 from 10:30 AM through 4 PM, except for one 30 min break in the observation time, showed the resident remained in his/her wheelchair the entire time. In an interview on 6/20/12 at 4 PM, the resident stated she had not laid down during the 30 minute break in observation. The resident was alert and oriented. d. Interview with the DON on 6/21/12 at 2:15 PM, revealed skin assessments were to be completed for all residents each week. She	F 314		

7/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 314	Continued From page 31 further stated nursing staff are to follow physician orders and complete wound care as prescribed. 3. Observation on 6/18/12 at 5:38 PM revealed resident #19 had a bariatric (oversized) bed without an air overlay mattress. On 6/19/12 at 10:10 AM the resident refused to allow a nurse surveyor to observe CNAs #6 and #8 who were providing personal care. After completing care, CNA #8 stated the resident had a "small slit" (described as an open area) at the "top of the crack" between the buttocks. The CNA stated they applied Calazime (a barrier cream) to the area after completing personal care. Review of the medical record showed the open area was first identified in nursing notes dated 3/28/12. The last documentation found in the nursing notes was dated 3/30/12 at 4 AM. It read: "Open area remains to buttocks. Calazime applied." Review of the skin checks showed they were not completed weekly, but there was no mention of the open area when they were completed. Review of the 4/3/12 care plan verified the resident had a "slit in coccyx, between upper buttocks." The interventions listed were "Wound and Skin Protocol: Calmazine between upper buttocks. Barrier wipes. Nurse to do visual check after pericare is completed after bms when possible." The following deficient practice was identified: a. During an interview on 6/20/12 at 10:45 AM, wound care nurse #1 stated she was "unaware" of any sacral skin issues, but after reviewing the resident's record, the wound nurse stated she did remember. However, she was unable to find any further documentation related to the wound. During the interview, the nurse also stated the resident's mattress was not a pressure	F 314		

12/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 314	Continued From page 32 relieving mattress and that she had not been informed of any concerns for the resident. She confirmed the open area was in a "pressure sore area" and had not been assessed by the wound care team. b. On 6/20/12 at 1:30 PM the wound care nurse reported she had assessed the resident's sacral/coccyx area and the resident's skin was intact. However, it had been open (Stage II pressure ulcer) and was still reddened and fragile. She stated the resident had never had an air overlay mattress. c. Review of the "Wound Protocol" last revised 4/12/12 showed staff were to "Describe Location/Stage of Wound...Assessment/Evaluation: Perform skin assessment/evaluation...Note location, size and appearance of affected area(s)...Location, appearance, size, and staging (if pressure ulcer use E-Z graph classifications)...May use skin creams prn to affected areas at risk: Calazime...Air mattress overlay...Document assessment/evaluation, interventions and residents response...Document on the wound in IDT notes...Complete weekly skin assessment/evaluation...and document in MAR. Document the wound on the E-Z graph sheet...weekly..." d. The ointment specified in the resident's care plan was not listed in the "Wound Protocol."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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	F 315	F 315 Ensure a resident who enters the facility without a catheter is not catheterized unless the residents clinical condition demonstrates need. The facility will ensure this will occur by: Resident # 87 • Drainage bag tubing removed from over rail to facilitate urine drainage 06/19/12 • On the spot training of staff 06/19/12 **Identification of other residents will occur by:** Residents with catheters have the potential to be affected by inappropriate drainage tube placement **Systemic process:** • Staff education regarding urinary catheter management upon hire, annually and as needed • Staff education regarding policy **Outcome:** 100% of residents with catheters will have catheter management per policy • DON or designee will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	07/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

(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 315	Continued From page 33 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's policies and procedures, the facility failed to ensure appropriate care was provided to prevent bladder infections for 1 of 4 residents (#87) who had an indwelling catheter. The findings were: Observation on 6/19/12 at 4:35 PM showed resident #87 had an indwelling catheter for bladder drainage. The tubing from the bladder to the drainage bag was draped over the side railing; therefore, the urine was not able to drain from his/her bladder. An observation at 4:55 PM showed the indwelling catheter remained draped over the railing. At that time, unit manager #1 acknowledged the catheter tubing was not to be positioned in a manner that did not promote bladder drainage. Review of the policy and procedure for urinary catheter care, last revised March 2012, showed staff should prevent urine from flowing back into the bladder.	F 315		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.	F 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 319	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 3 residents (#12) identified as needing psychological services received the service. The findings were: Review of the medical record for resident #12 showed the resident was admitted on 4/12/12 with diagnoses that included failure to thrive, pancreatitis, diabetes, anemia, and major depression. Additional review of the medical record showed that after admission to the facility, the resident was frequently transported back and forth between the facility and the local hospital for acute care. Review of the physician's orders and progress notes showed the physician ordered several acute care procedures as well as a psychological consult on 6/12/12. This review also revealed nursing staff acknowledged the order by writing on the bottom of the physician's note "noted 6/13/12 at 1750." During an interview on 6/20/12 at 9:48 AM, social worker #2 revealed she was unaware of the order for a psychological consult. The social worker also confirmed staff had not followed the physician's order.	F 319	F 319 Ensure a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. The facility will ensure this will occur by: Resident # 12 • 06/21/12 Social Services confirmed referral to Dr. Fisher PhD completed, ordered 06/12/12, she received order 06/20/12 • Staff did follow physician order, Social Services unaware of order, reviewed communication process with Social Service notification of behavioral health consults • Care plan updated 06/21/12 **Identification of other residents will occur by:** Any resident triggered on the comprehensive assessment for behavioral or psychosocial difficulties have the potential to be affected **Systemic process:** • Social Service staff will receive copies of schedules for behavioral health consults/appointments monthly and PRN. • Social Services will be notified of any consults for mental health • Policy review and revision as appropriate • Referral request form review • Staff education regarding referral request form utilization	07/27/12
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	**Outcome:** 100% of mental health referrals will be communicated to Social Services • Social Services will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 329	Continued From page 35 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen for 2 of 23 sample residents (#11, #83) was free of unnecessary medications. The findings were: 1. According to the physician's orders and the MARs, resident #11 received lorazepam (Ativan, antianxiety medication) 1 mg twice daily. Since the order was rewritten every two months, there was no indication how long the resident had received this dose. Further review of the medical record failed to produce a statement from the physician indicating the benefits of continued use of the psychoactive medication at that dose outweighed the risks. Interview with unit manager	F 329	**F 329 Residents drug regimen must be free from unnecessary drugs** The facility will ensure this will occur by: Resident # 11 Attending physician has reviewed. Lorazepam has been decreased from previous higher doses, (use to be 4 mg a day in 2005) . Current dose maintained for anxiety associated with traumatic brain injury. Psych consult completed with follow up for worsening symptomatic psychosis with recent initiation and increase in ability . Consideration will be made to attempt trial of further dose reduction of lorazepam once stabilization of mental status 07/12/12 Resident # 83 Celexa has been discontinued after attending physician review with order to monitor for any increase symptoms of depression. 07/12/12 **Identification of other residents will occur by:** • Monthly pharmacy report regarding psychotropic, antidepressant and sedative/hypnotics and antianxiety medications currently provided to DON/MDS/Social Services and Nurse Managers. • Review of list and chart audit to identify documentation of risk versus benefit and indication. **Systemic process:** • All residents receiving psychotropic, antidepressant and sedative/hypnotics and antianxiety medications will have pharmacy review related to risk/benefit documentation • All new admissions will have medication review for risk/benefit documentation • Annually, on significant change and on readmission review residents receiving medications requiring risk versus benefit for documentation compliance	07/27/12

7/17th M

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 329	Continued From page 86 #1 on 6/20/12 at 5 PM revealed the resident had been on Ativan 1 mg twice daily since 1/18/11 (over 18 months). She further stated she was unable to find a physician's clinical rationale for continued use of the medication at that dose; nor was there evidence an attempted dose reduction was clinically contraindicated. 2. According to the physician's orders and the MARs, resident #83 received Celexa 10 mg daily for depression. Review of the 4/24/12 monthly pharmacy review showed the pharmacist identified the need for a statement from the physician indicating the benefits of continued use of the psychoactive medication at that dose outweighed the risks. Review of the medical record showed the medication at the current dose was initiated in 2010. Further review of the medical record and interview with unit manager #1 on 6/21/12 at 2:45 PM revealed no evidence of the physician's clinical rationale for continued use of the medication at that dose.	F 329	**F329 continued** • Staff education regarding behavior management documentation/ effectiveness of medications • Policy review and revision **Outcome:** 100% of residents on psychotropic, antianxiety, sedative hypnotics and antidepressant medications will have risk/benefit documentation in medical record • Pharmacy will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and addressed.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428	**F 428 Drug regimen must be reviewed at least once a month by a licensed pharmacist and report irregularities** The facility will ensure this will occur by: **Resident # 11** Attending physician has reviewed. Lorazepam has been decreased from previous higher doses, (use to be 4 mg a day in 2005) . Current dose maintained for anxiety associated with traumatic brain injury. Psych consult completed with follow up for worsening symptomatic psychosis with recent initiation and increase in Abilify . Consideration will be made to attempt trial of further dose reduction of Lorazepam once stabilization of mental status 07/12/12 **Identification of other residents will occur by:** • Monthly pharmacy report regarding psychotropic, antidepressant and sedative/hypnotics and antianxiety medications currently provided to DON/MDS/Social Services and Nurse Managers. • Review of list and chart audit to identify documentation of risk versus benefit and indication.	07/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

(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 428	Continued From page 37 by: Based on medical record review and staff interview, the facility failed to identify irregularities for 1 of 20 sample residents (#11) whose monthly medication regime was reviewed. The findings were: Review of the medical record and interview with unit manager #1 on 6/20/11 at 5 PM revealed resident #11 had received Ativan 1 mg twice daily since 1/18/11. Review of the past year's monthly medication reviews showed no evidence the pharmacist identified use of Ativan at that dose for that length of time as an irregularity. At 5:20 PM that day the unit manager reported she had checked with the pharmacy department, and there was no evidence the pharmacist identified the continued use of the medication at the same dose as an irregularity.	F 428	**F428 continued** **Systemic process:** • All residents receiving psychotropic, antidepressant and sedative/hypnotics and antianxiety medications will have pharmacy review related to risk/benefit documentation • All new admissions will have medication review for risk/benefit documentation • Annually, on significant change and on readmission review residents receiving medications requiring risk versus benefit for documentation compliance • Staff education regarding behavior management documentation/ effectiveness of medications • Policy review and revision **Outcome:** 100% of residents on psychotropic, antianxiety, sedative hypnotics and antidepressant medications will have risk/benefit documentation in medical record • Pharmacy will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	
F 431 SS=E	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.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

(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 431	Continued From page 38 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's policies and procedures, the facility failed to ensure medication labels displayed an expiration date in 2 of 4 areas observed where medications were stored. The findings were: 1. Observation on 6/20/12 at 2:50 PM with RN #1 showed the following medications found in the storage room located in Neighborhood 5 were not labeled with a visible expiration date: a. One bottle of sodium polystyrene sulfonate for resident #19. b. One stock bottle of acetaminophen 325 mg tablets. c. Two packages of hydrocodone with acetaminophen 5/500 mg totaling 60 tablets for resident #46. d. One bottle of Bayer aspirin.	F 431	**F 431 Drugs and biological must be labeled in accordance with currently accepted professional principles including expiration dates** The facility will ensure this will occur by: Resident # 19, 46, 57 • Medications sent back to pharmacy and correctly labeled 06/20/12 Stock medications • Expired medications destroyed per policy 06/20/12 • Medication labels have expiration dates, if no expiration date, statement on label reads "This prescription expires 1 year from label dispense date unless otherwise indicated" 06/20/12 **Identification of other residents will occur by:** All residents receiving medications have the potential to be affected **Systemic process:** • Review current labeling policies • Staff education on expiration dating of medications and labeling • Review and revise current medication inspection checklist 07/12/12 • Review and revise pharmacy medication area inspection policy to include Pioneer Manor **Outcome:** 100% medications correctly labeled with expiration date • Pharmacy will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	07/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 431	Continued From page 39 The RN at the time confirmed all the medications were available for use and the expiration dates were not visible. 2. Observation on 6/20/12 at 4:10 PM with LPN #2 showed a partially used tube of hydrocortisone cream 1% solution for resident #57 in medication cart #4 located in Neighborhoods #3 and #4. The tube of medication was not labeled with a visible expiration date. The LPN at that time confirmed the expiration date was not visibly displayed. 3. Interview with the DON on 6/20/12 at 5:15 PM stated the nursing staff should check the medications received from the pharmacy for expiration dates and if they are incorrectly labeled, the medications were to be returned. 4. Review of the policy and procedure for storage of medication, last dated April 2007, showed; "Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy for proper labeling before storage."	F 431		
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,	F 441	**F 441 Establish and maintain infection control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection** The facility will ensure this will occur by: Resident #8, • Continue to audit hand hygiene compliance • Provide on the spot education for staff who do not comply with hand hygiene Resident #26 • Unable to identify resident #26 on list provided to facility Resident #10 and #66 • Immediate on the spot training of physical therapy staff regarding hand hygiene, dressing changes, appropriate gloving techniques 06/21/12 • PT did education on 06/26/12 and 07/11/12 Training completed by both wound certified therapists and infection prevention staff Resident #48 • Replacement of current sanitwipes with Hydrogen Peroxide clean disinfectant wipes (requires kill time 1 minute versus 2 minute wet time) More effective, less kill time, evidence based information available • On the spot education 06/22/12 regarding new Hydrogen Peroxide clean disinfectant wipes • Staff education 07/12/12 Resident #87 • Immediate on the spot training of Physical Therapy staff regarding hand hygiene, dressing changes, appropriate gloving techniques 06/20/2012, PT did education on 06/26/2012, and 07/11/12. Training completed by both wound certified therapists and infection prevention staff	07/27/12

8/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 441	Continued From page 40 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and review of policies and procedures, the facility failed to ensure staff followed appropriate infection control practices during 6 random observations. The findings were: 1. On 6/19/12 at 9:50 AM CNAs #2 and #5 were observed while providing personal care for non-sample resident #8 who had been incontinent of bowel. CNA #2 completed perineal care and then, without removing her gloves and	F 441	F 441 continued Identification of other residents will occur by: All residents have the potential to be affected by infection prevention practices Systemic process: • Staff education regarding aseptic technique, hand hygiene, equipment cleaning and wound care • Organizational approach to implementing new products to ensure cleaning materials consistent • Competency demonstration for therapy and nursing staff (wound care, hand hygiene, aseptic technique) upon hire and annually and prn • Policy and procedure review Outcome: • 100% medications correctly labeled with expiration date • • 100% of staff will demonstrate hand hygiene compliance • • 100% of staff will demonstrate competency with Hydrogen Peroxide disinfectant wipes • 100% of dressing changes will be completed per policy • Infection Prevention will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 441	Continued From page 41 performing hand hygiene, completed morning care. The CNA touched the resident's catheter tubing and drainage bag, clothes, sling and manual lift, and electric wheelchair while wearing the same gloves worn to cleanse the resident of feces. After completing morning care, the CNA removed the gloves and washed her hands. When asked about her technique at 10:35 AM that day, the CNA stated she should have changed her gloves after completing perineal care for the resident. 2. After using a sit-to-stand lift to transfer resident #48 to a wheelchair on 6/19/12 at 10:40 AM, CNAs #5 and #6 pulled a "Super Sani-Cloth" wipe from a bag on the back of the lift and rubbed it over the bars of the lift. When questioned about the practice, both replied they would let the lift air-dry for three minutes before using it again. When asked if there was a wet contact time for the wipe, neither CNA was aware of any. Review, with the CNAs, of the manufacturer's instructions printed on the package revealed disinfection required staff to "...remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time. Let air dry." On 6/21/12 at 7:05 AM both the DON and unit manager #1 said the purpose of wiping the lift was to sanitize, or disinfect, it. 3. Observation on 6/20/12 at 2:15 PM showed PT #1 changed the dressing for resident #87. The physical therapist donned a pair of gloves then removed the dressing. She removed the contaminated gloves and donned a clean pair of gloves without first performing hand hygiene. The	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 441	Continued From page 42 therapist then applied the clean dressing. Review of the policy and procedures for wound care, last revised 2/8/12, showed after removing the dressing and gloves, hands are to be washed before applying another set of gloves to complete the dressing change. 4. Observation on 6/19/12 at 12:05 PM showed CNA #7 provided perineum care to non-sample resident #26. After the CNA completed the resident's perineal care, the CNA removed her gloves, but did not cleanse her hands. She continued to assist the resident, adjusted the call light, opened a cabinet drawer to remove socks and provided him/her a blanket. Interview with the DON on 6/21/12 at 2 PM revealed the CNA needed to wash her hands after removing her gloves and before continuing with other care. Review of the policy and procedures for perineal care, last revised on 2/12, showed gloves are to be removed and hands washed thoroughly before other comfort measures are provided. 5. On 6/19/12 at 12:25 PM, PT #1 and PT #2 were observed performing dressing changes on the stasis ulcer on resident #86's leg. During the observation, the stasis ulcer was debrided and the vac [vacuum assisted wound closure machine] removed and replaced. Continuous observation revealed the following concerns: a. The clean dressings, sponge, and plastic wound covering dressing were cut with the same pair of scissors that were used to remove the soiled dressings. The scissors were not disinfected or cleaned between the tasks. b. The packaged dressings were opened and placed on a disposable pad positioned under the resident's leg. However, the contaminated	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	585022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 9TH ST GILLETTE, WY 82716

(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 441	Continued From page 43 dressings and bloody drainage also had contact with the same disposable pad. c. PT #1 handled the cleanser spray bottle with the same gloved hand that had direct contact with the bleeding wound. d. PT #1 wore two pairs of gloves. She used the outer pair to remove the soiled dressings, and then applied the clean dressings with the second pair without performing hand hygiene. In addition, hand hygiene was not performed until after all of the following tasks were completed: the soiled dressings removed and discarded; the wound and bloody drainage cleaned; ointment applied; the vac removed and replaced; and the clean dressings applied. e. Interview on 6/20/12 at 4:20 PM with PT #1 and PT #2 revealed they did not realize the above observations had occurred, and both verified this was not an acceptable standard of practice. 6. PT #1 was observed performing pressure ulcer care and dressing changes for resident #10 on 6/19/12 at 1:10 PM. During the observation PT #1 wore two pairs of gloves. She removed one pair after completing the dressing change on the resident's leg wound, but did not perform hand hygiene prior to using the second pair for removing the dressing that covered the pressure ulcer on the right buttock. When she removed the gauze packing, the yellow drainage from the pressure ulcer got on the PT's gloves and disposable pad positioned under the resident. The PT removed the gloves, and again did not perform hand hygiene before she used her ungloved hands to spray the pressure ulcer with the wound cleansing solution. Then she donned a clean pair of gloves and irrigated the area,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 441	Continued From page 44 applied Santyl cream, packing, and dressings. Hand hygiene was not observed until all of the above tasks were completed. Interview on 6/20/12 at 4:20 PM with PT #1 revealed she did not realize the above observations had occurred. At that time PT #1 and PT #2 both verified this was not an acceptable standard of practice. 7. Review of the facility's Infection Prevention Policy and Procedure, reviewed 2/13/12, showed the procedure for dressing changes included the following sequential steps: a. Wash hands. Don gloves. b. Remove old dressing; place in plastic bag. c. Remove contaminated gloves; put in plastic bag with contaminated dressings. d. Wash hands or use antiseptic hand sanitizer. e. Don sterile gloves. f. Apply new dressings, using no-touch techniques. g. Remove gloves and wash hands. 8. Interview with the infection preventionist on 6/21/12 at 11 AM revealed staff were expected to follow the above Infection Prevention Policy and Procedure.	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	F 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 496	Continued From page 45 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: Based on review of personnel records and staff interview, the facility failed to ensure 1 of 3 CNAs (#1) was placed on the CNA registry after receiving her CNA certification from the Wyoming State Board of Nursing. The findings were: Review of the personnel records for CNA #1 on 6/21/12 at 10:15 AM showed her CNA certification was issued on 5/8/12. Further review of her record showed no evidence her name was placed on the CNA registry. Interview with the Human Resources staff on 6/21/12 at 11 AM	F 496	**F 496 Facility must receive registry verification that the individual has meet competency evaluation requirements** The facility will ensure this will occur by: • CNA #1 abuse registry verification completed June 22, 2012 **Identification of other residents will occur by:** All staff have the potential to be affected and residents as well **Systemic process:** • Human Resources will weekly verify departments that hire CNA's/NA's and CNA abuse registry registration • Human Resources to fax paperwork to Department of Health once CNA is licensed, verify after three days registration is complete o If not there refax and re-verify after another three days • Weekly meeting with Human Resources and Pioneer Manor DON to verify CNA registry and verify CNA abuse registry compliance • Organization wide approach utilizing above process for all departments hiring NA or CNA staff • Process/Policy review and revision **Outcome:** 100% of CNA's are registered on CNA abuse registry Human Resources will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	07/20/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 496	Continued From page 46 revealed the CNA had not been placed on the registry because the Human Resources staff did not know the CNA had received her certification.	F 496		
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, the facility failed to secure clinical record information against unauthorized access in 3 of 3 record storage areas. The findings were: On 6/20/12 at 8:45 PM MDS coordinator #2 stated "we had to call the janitor" to obtain access to medical records. On 6/21/12 at 6 PM the administrator stated the janitor had access to the locked box containing the key to medical record storage areas. At that time a tour of the area with the administrator verified the medical record key to the storage areas was in a locked box in the janitor's office. One room contained two carts with over 75 large boxes, each approximately 20	F 516	07/27/12 F 516 A facility may not release information that is resident identifiable to the public The facility will ensure this will occur by: • Medical Record key given to medical record staff 06/22/12 **Identification of other residents will occur by:** All residents have the potential to be affected by inappropriate release of information **Systemic process:** • ~~Key sent to Plant Operations locksmith per policy 07/13/12~~ Execute • Medical record staff, Medical Records supervisor and ~~Plant ops locksmith~~ only authorized personnel ~~Delete~~ • Review and revise organization policy for authorized access to medical records to include Pioneer Manor access authority completed 07/12/12 **Outcome:** Medical records will be secured 100% of the time Medical Records will collect Data and evaluation will be reported quarterly to the QA meeting, with discrepancies investigated and resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 516	Continued From page 47 inches long by 12 inches wide, containing clinical and billing information. The second room was off a women's restroom, and the third was the medical records office. The office, unoccupied at the time, contained lockable file cabinets, but the key was in two of the cabinets and the office door had been closed but not locked.	F 516		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs.	PROVIDER # 535022	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 6/21/2012
NAME OF PROVIDER OR SUPPLIER: PIONEER MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE: 900 W 8TH ST GILLETTE, WY		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 285	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete the "Assessment of Medical Necessity for Long Term Care" (known as the LT101) prior to admission for 1 of 20 sample residents (#48). The findings were: According to the admission face sheet, resident #48 was admitted on 1/3/12. Review of the LT101 showed it was not completed until 2/24/12. On 6/20/12 at 1:52 PM, social worker #1 confirmed she knew the form needed to be completed before admission. She stated it was late due to the residents "transfers to other facilities."