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

PRINTED: 07/25/2012
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
	535040	A. BUILDING _____ B. WING _____	C PP 07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 000	INITIAL COMMENTS	F 000		

The following common abbreviations are used throughout this document:
ADLs - activities of daily living
CAAs - care area assessments
CNA - certified nursing assistant
DON - director of nursing
MAR - medication administration record
MDS - Minimum Data Set
mg - milligram
RN - registered nurse
SCU - secure care unit
Less commonly used abbreviations will be annotated in each deficiency where used.

F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	

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, resident and staff interview, and review of posted information and resident council minutes, the facility failed to provide care and services in a dignified, respectful manner for 1 non-sample and 3 sample residents (#1, #9, #23, #32). The findings were:

As pertaining to entering resident rooms without permission:

1. Interview with the DON on 7/12/12 at 3:22 PM revealed staff were to knock and then wait for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] NHA 8/24/12

For deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

8/20/12 POC accepted with changes per telephone call @ 10:22 AM with Kelli Logges. [signature] RN

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F 241	Continued From page 1 permission before entering a resident's room. Failure to adhere to this expectation was identified during the survey as follows: a. After obtaining permission from non-sample resident #1, observation on 7/10/12 at 8:52 AM revealed CNA #9 provided appropriate incontinence care for the resident, who had been incontinent of bowel and bladder. During this provision of care, the CNA positioned the resident to face the wall so s/he was unable to see who was in the room. Environmental aide #4 knocked, and without waiting for permission, immediately entered the room even though the CNA called out, "Resident care." At 9 AM RN #6 knocked, said "Nursing" and immediately came in even though the CNA again called out, "Resident care." Neither the environmental aide nor the RN spoke to the resident or apologized for entering during personal care. At 9:03 AM the resident suddenly stated, "I don't want those people watching!" Observation by the surveyor ceased at that time. b. Observation on 7/10/12 at 7:23 AM showed resident #23 was sleeping. At 7:25 AM, CNAs #9, #5, and #2 entered the room, and CNA #9 stated they were going to get the resident up. During the provision of incontinence care and assistance with dressing and transfer to the recliner, a process taking over 20 minutes, the administrator, environmental aide #4, RN #6, and the DON each knocked and then immediately entered the room. The DON did say, "Nursing," but no one waited for permission to enter. As pertaining to an undignified dining experience: 1. Observation on 7/10/12 at 7:23 AM showed resident #23 was sleeping with the uncovered breakfast meal on the overbed table. It was	F 241	F 241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in a full recognition of his/her indivuality. A) Residents # 1, 9, 23 and 32 will always have their door knocked on and staff will wait to be given permission before entering the resident's room. B) We will assume other residents have been affected by the deficient practice, and that they too will have their doors knocked on and staff will wait to be given permission before entering the resident's room. C) All staff will be in serviced on the importance of knocking on a residents door and waiting for permission before entering as well as signing off on the policy that discusses knocking and waiting for permission before entering. D) There will be monthly audits done to ensure that all staff is knocking on resident's rooms and waiting for permission to enter the resident room. The audit will be done by DON or designee. The audits will be brought to QA on a monthly basis until resolved and then reviewed bi-	

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F 241	Continued From page 2 unknown how long the meal had been uncovered at the time of the observation. At 7:25 AM, CNAs #9, #5, and #2 entered and CNA #9 confirmed the meal was untouched. CNA #9 stated they were going to get the resident up and into the recliner for the meal. After dressing and transferring the resident to the recliner, at 7:45 AM (22 minutes after the initial observation) CNA #9 offered the resident a bite of breakfast. The meal (consisting of two fried eggs, ground ham covered with gravy, cold cereal, and toast) was not rewarmed nor did any of the six staff present in the room at that time offer to warm it. 2. Observation on 7/10/12 from 7 AM to 9 AM revealed the following concerns: a. Resident #32 was observed seated at a dining table in the SCU dining room at 7:00 AM when the surveyor arrived. At 8:15 AM a tray of food was placed in front of the resident (wait time of more Than 1 hour, 15 minutes). b. Resident #9 was seated at a dining room table in the SCU dining room at 7:16 AM. At 7:48 AM the resident was observed asleep in his/her wheelchair. At 8:19 AM a food tray was placed in front of the resident (wait time of 1 hour, 3 minutes). c. A wall bulletin board in the SCU next to the dining room stated "breakfast served at 6:15 AM." Interview with the kitchen manager on 7/10/12 at 10:48 AM revealed the breakfast serving time was changed a week ago. Staff in the SCU dining room requested breakfast be served after the main dining room rather than before. d. A confidential interview of 10 residents on 7/10/12 at 2 PM revealed the majority of residents agreed it sometimes took a long time for food to be served. Review of the resident council meeting	F 241	annually thereafter. This will be completed by 9/1/12. 8/24/12 PP E) Resident #23 will have his food warmed up if has cooled off. F) We will assume other residents have been affected by the deficient practice, and that they too will have their food warmed if it has cooled off. G) All staff will be in serviced on the importance of a residents food being warm at the time the resident actually sits down to eat. H) #32 and #9 residents will not have to wait for their meals. I) We will assume other residents have been affected by the deficient practice, and that they too will have their food served to them instead of having to wait for it. J) All staff will be in serviced on the importance of a residents receiving their food in a timely manner. K) The wall bulletin board in the SCU next to the dining room has been changed now states that "breakfast served at 7 AM" This was done by 7/12/12. L) Meals will be served on time. Audits will be done a weekly basis to ensure that meals are being served on time. The audits will be done by the kitchen supervisor or designee and	

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F 241	Continued From page 3 minutes from 4/26/12 confirmed the residents were concerned with slow meal service time.	F 241	will be addressed at QA on a monthly basis until resolved and then quarterly after to ensure that residents are	
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 Documentation of participation in assessment.	F 272	receiving their meals on time. Residents will also have the ability to address at monthly resident council meetings.	9/30/12 8/20/12

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F 272	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interview, the facility failed to provide comprehensive assessments in a variety of areas for 4 of 12 sample residents (#9, #19, #43, #45). The findings were: 1. Review of the 5/11/12 significant change MDS assessment for resident #19 showed delirium, cognitive loss, ADL function, urinary incontinence, psychosocial well being, activities, falls, dental care, pressure ulcers and pain were triggered for comprehensive assessment. Further review and interview on 7/11/12 at 3:40 PM with the MDS coordinator revealed none of the comprehensive assessments had been developed for the triggered areas. 2. According to the 5/22/12 admission MDS assessment, resident #43 triggered for comprehensive assessments in the areas of cognitive loss, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well being, behavioral symptoms, falls, dehydration, dental care, psychotropic medications, and return to the community. Detailed review of the medical record showed the comprehensive assessments were lacking. On 7/10/12 at 4:20 PM, RN #12 stated she was the nurse responsible for completing those assessments. At that time, she confirmed comprehensive assessments in the aforementioned areas had not been done.	F 272	F 272 The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A) Resident#19 will have a compressive assessment done for the trigged areas of delirium, cognitive loss, ADL function, urinary incontinence, psychosocial well being, activities, falls, dental care, pressure ulcers and pain. B) Resident # 43 will have comprehensive assessments done for cognitive loss, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well being, behavioral symptoms, falls, dehydration, dental care, psychotropic medications, and return to the community. C) Resident #45 will have comprehensive assessments done for cognitive loss, ADL function, urinary incontinence, psychosocial well being, mood state, behavioral symptoms, activities, falls, nutritional status, pressure ulcers, psychotropic drug user and pain. D) Resident #9 will have comprehensive assessments done.	

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F 272	Continued From page 5	F 272	E) MDS coordinator and DON will receive education on the importance of comprehensive assessments. F) The CAA's for the comprehensive assessments will be done by ~~9/30/12~~ 8/20/12 for all residents that have triggered them. G) There will be monthly ~~weekly~~ audits done on comprehensive assessments and CAA's by the MDS coordinator or designee and reviewed with the IDT weekly until all issues all resolved and then brought to QA on a bi-yearly review.	pp 8/20/12 pp 9/30/12 8/20/12

3. Review of the 5/28/12 admission MDS assessment for resident #45 showed cognitive loss, ADL function, urinary incontinence, psychosocial well being, mood state, behavioral symptoms, activities, falls, nutritional status, pressure ulcers, psychotropic drug use, and pain were triggered for comprehensive assessment. Further review and interview on 7/12/12 at 11:30 AM with the medical records manager revealed none of the comprehensive assessments had been developed for the triggered areas.

4. Review of the medical record for resident #9 revealed comprehensive assessments were not found in the record. Interview with the MDS coordinator on 7/10/12 at 10:48 AM revealed she was unable to complete the assessments.

5. During an interview on 7/10/12 at 4:20 PM, RN #12 confirmed she was the nurse who was to complete the CAAs for the comprehensive assessments. She stated if the CAAs were not in each resident's record, they had not been completed because she was reassigned to work as a floor nurse and was not allowed overtime to complete the assessments.

According to the 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 information

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F 272	Continued From page 6 gathered thus far to make a clear issue or problem statement." The following concerns related to lack of comprehensive assessments were identified:	F 272		
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 complete a significant change MDS assessment for 1 of 3 sample residents (#23) who should have had that assessment. The findings were: According to the 3/9/12 quarterly MDS assessment, resident #23 required limited assistance with bed mobility, transfers, dressing, toilet use, and bathing. The resident was independent with locomotion on the unit. Comparison of that assessment with the one dated 6/6/12 revealed the resident had declined	F 274	F 274 The facility will 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. A) A significant change assessment will be done on resident # 23. B) The MDS coordinator will be going to MDS Boot Camp to help her with the importance of significant changes. C) The IDT team will hold weekly meetings to ensure that we have identified any residents that may need a significant change. This will be reviewed monthly at QA until resolved and then quarterly thereafter. 9/30/12 8/2d/12	

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F 274	Continued From page 7 In several areas. S/he required extensive assistance with bed mobility, transfers, dressing, and toilet use and total assistance with locomotion on the unit and bathing. Interview with the MDS coordinator on 7/12/12 at 10:40 AM revealed the resident was having symptoms of transient ischemic attacks (mini-strokes) between 5/21/12 and 5/23/12. She confirmed a significant change assessment should have been conducted.	F 274		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete an annual assessment in a timely manner for 1 (#9) of 4 sample residents who required an annual evaluation. The findings were: Review of the medical record for resident #9 revealed an annual MDS assessment was conducted on 3/21/11. Further review revealed the next annual assessment was completed on 6/21/12. Interview with the MDS coordinator on 7/10/12 at 10:48 AM confirmed the annual assessment was not completed in March 2012 as required.	F 275	F 275 The facility will conduct comprehensive assessments of a resident not less than once every 12 months. A) Resident # 9 had a comprehensive assessment done on 6/21/12. B) MDS Coordinator will be going to MDS Boot camp. We have also been working with our software company to ensure that we have a correct calendar to refer to ensure that we don't miss any residents and their quarterly and annual assessments. C) Weekly audits will be done to ensure that all comprehensive assessments are being done on all residents; once the issue is resolved it will be brought to QA on a quarterly basis.	9/30/12 8/24/12
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		

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F 278	Continued From page 8 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 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interview, the facility failed to provide complete, signed assessments for 7 of 12 sample residents (#9, #19, #22, #23, #32, #43, #45). In addition, inaccurate assessments were provided for 2 of 12 sample residents (#19, #34). The findings were:	F 278	F 278 The facility will ensure that each individual that completes a portion the assessment will sign and certify the accuracy of that portion of the assessment. A) Resident's 9, 19,22,23,32,43,45,19 & 34 will have their MDS assessment signed for CAA Summary or Sections Z0400 and/or Z0500 or both. The assessments will be completely signed by the date printed in Section Z0500B. This will be completed by ~~9/30/12~~ 8/26/12 B) Resident #34 will have the Effexor XR and the Ativan added to the list in section N of the assessment. C) Resident # 19 will have the antidepressant use and turning/reposition program added to the significant change MDS dated 5/11/12. D) The MDS Coordinator will be attending a MDS Boot Camp. A weekly meeting will be held with the IDT to ensure that all appropriate sections are completed on a timely basis for all residents who are do. This will be visited on a bi-weekly basis until resolved; then quarterly thereafter at QA.	ff

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F 278	Continued From page 9 1. Review of the MDS assessments showed staff failed to sign either Section V (CAA Summary) or Sections Z0400 and/or Z0500A, or both, (Assessment Administration) as follows: a. Resident #9 for the 6/21/12 annual assessment. b. Resident #19 for Section V of the 5/11/12 significant change MDS. c. Resident #22 for the 6/7/12 quarterly assessment. d. Resident #23 for the quarterly assessment dated 6/6/12. e. Resident #32 for the 1/18/12 quarterly assessment. f. Resident #43 for the 5/22/12 admission assessment. g. Resident #45 for the 5/28/12 admission MDS. Additionally, Section V wasn't signed. On 7/10/12 at 11:50 AM the MDS coordinator stated she was unaware the assessments needed to be completely signed by the date printed in Section Z0500B. 2. Medical record review for resident #34 revealed the resident was admitted on 10/31/11. Several of the medications the resident was taking at the time of admission included Effexor XR (antidepressant) and Ativan (antianxiety). Effexor was not listed in section "N" of the admission MDS assessment. In addition, Ativan was not listed in section "N" of the 5/11/12 quarterly MDS. At the time of survey, the resident was still taking these two medications. Interview with the MDS coordinator on 7/10/12 at 10:48 AM revealed she must have made a mistake as she was new to the job. 3. Review of the 2012 MARs for resident #19	F 278	Social Service and Activities will have our software program downloaded on their computers to ensure that they do and sign their appropriate sections.	9/30/12 8/24/12

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F 278	Continued From page 10 revealed s/he had been continuously receiving daily doses of Lexapro for depression since December 2011. Review of the care plan showed staff were directed to reposition the resident every two to four hours. According to the care plan, this approach did not change when the care plan was reviewed and revised on 1/16/12, 4/2/12 and 6/18/12. Review of the 5/11/12 significant change MDS assessment showed use of an antidepressant and a turning/repositioning program were not identified in this assessment. Interview on 7/11/12 at 3:40 PM with the MDS coordinator revealed the 5/11/12 significant change MDS assessment needed to be corrected to include the antidepressant use and turning/repositioning program.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

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	535040	A. BUILDING _____ B. WING _____	C 07/12/2012

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F 279	Continued From page 11 under §483.10(b)(4).	F 279	F 279	

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, and staff interview, the facility failed to develop an individualized care plan that reflected the current status for 5 of 12 sample residents (#9, #15, #23, #32, #34). The findings were:

1. Review of the 5/11/12 significant change MDS assessment for resident #15 showed s/he was frequently incontinent and required total assistance with toileting and personal hygiene care. Review of the corresponding care plan showed interventions regarding toileting and personal hygiene were lacking. Continuous observation on 7/10/12 from 7:15 AM to 1:10 PM revealed the resident received 80 mg of Lasix (a diuretic) at 8 AM and staff did not provide toileting assistance until 1:10 PM. At 1:10 PM, CNAs #5 and #2 assisted the resident to the bathroom and removed the urine soiled disposable brief before they positioned him/her on the bathroom commode. In an interview on 7/10/12 at 4:40 PM the MDS coordinator acknowledged the care plan failed to address the resident's toileting needs.

2. According to the 12/7/11 annual MDS assessment, resident #23 displayed two mood indicators - trouble falling/staying asleep or sleeping too much and feeling tired or having little energy. Review of the 6/6/12 quarterly MDS assessment showed the resident exhibited occasional bladder incontinence. Review of the care plan showed neither of these issues were appropriately addressed; mood state was not

F 279
The facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.
A) Resident # 15 will have a care plan reflecting her toileting needs. Resident #15 will be toileted every two hours or as needed. CNA's will be in serviced on the importance of all residents being toileted every two hours.
B) Resident #23 will have trouble falling/staying asleep or sleeping too much and feeling tired or having little energy and occasional bladder incontinence added to his care plan. All residents care plans will be reviewed at care plans meetings on a quarterly basis to ensure that all issues are being addressed in the care plan.
C) Resident # 9 will have interventions added to her care plans addressing skin breakdown and urinary tract infections. All residents care plans will be reviewed at care plan meetings on a quarterly basis to ensure that all interventions are being listed on the care plan for any areas that may be triggered.

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F 279	Continued From page 12 care planned at all, and the plan for urinary incontinence lacked interventions. On 7/12/12 at 10:40 AM, the DON confirmed the lack of an appropriate plan for these areas. She further stated the resident reentered the facility on 7/9/12, but an interim care plan had not been developed even though the initial nursing assessment had been completed. 3. Review of the 3/21/11 annual MDS assessment and CAA for resident #9 revealed s/he triggered in several areas including frequent urinary incontinence. Review of the urinary incontinence care plan revealed goals of "will not develop skin breakdown" and "be free of urinary tract infection." There were no interventions identified to attain these goals. 4. Review of the 10/19/11 admission MDS assessment and CAA for resident #32 revealed s/he triggered in several areas including frequent urinary incontinence. Review of the urinary incontinence care plan showed goals of "will not develop skin breakdown" and "be free of urinary tract infection." However, interventions to attain these goals were not identified. 5. Review of the 10/31/11 admission MDS assessment and CAA for resident #34 revealed s/he triggered in several areas including frequent urinary incontinence. In addition, the 5/11/12 quarterly MDS assessment showed the resident was always incontinent of urine. Review of the urinary incontinence care plan listed goals of "will not develop skin breakdown" and "be free of urinary tract infection." Intervention strategies to attain these goals had not been identified.	F 279	D) Resident # 32 will have interventions added to her care plans addressing skin breakdown and urinary tract infections. All residents care plans will be reviewed at care plan meetings on a quarterly basis to ensure that all interventions are being listed on the care plan for any areas that maybe triggered. E) Resident # 34 will have interventions added to her care plans addressing skin breakdown and urinary tract infections. All residents care plans will be reviewed at care plan meetings on a quarterly basis to ensure that all interventions are being listed on the care plan for any areas that maybe triggered. F) The MDS Coordinator and DON will be attending a MDS Boot Camp; both sit on the IDT for care plans. The IDT will ensure that there will be interventions listed on all care plans for all residents and their current status. The IDT of the care plans will be in serviced on the importance of asking questions as to what interventions can be placed on identified problem areas. The IDT meets on a weekly basis, as residents come up for their annual or quarterly care plans, the current care plan will	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 13 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of internal reports, and staff interview, the facility failed to revise the care plans for 2 of 12 sample residents (#23, #43) to reflect each resident's current status. The findings were: 1. According to the nursing documentation and "Incident Report Audit," resident #23 had several falls during June 2012. Observation on 7/10/12 at 3 PM showed s/he had a pressure ulcer on the right buttock. Review of the resident's care plan showed "Potential for falls" and "Risk For	F 280	be updated to current status. The care plans for that week will be reviewed following day by MDS Coordinator and NHA or designee weekly until resolved and then quarterly thereafter. F280 The facility will ensure that the residents have the right to participate in planning care and treatment or changes in care and treatment. A) Resident #23 will have a care plan reflecting his/her current status; including potential for falls and risk for developing pressure ulcer. MDS coordinator will start attending fall committee to ensure that interventions are placed on the care plan B) Resident #43 will have a care plan that accurately reflects the residents independence. C) All residents will have care plans reflecting his/her current status and interventions addressing each residents needs. The MDS Coordinator and DON will be attending a MDS Boot Camp; both sit on the IDT for care plans. The IDT will ensure that there will be interventions listed on all care plans	9/30/12 8/24/12

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F 280	Continued From page 14 Developing Pressure Ulcer" had not been revised since 10/5/11, and neither reflected the resident's current status. Additional interventions to help prevent or minimize falls had been developed by the facility's "Fall Committee"; however, these interventions were not documented in the care plan to ensure direct care staff were aware of them. A Stage II pressure ulcer was first identified on 6/8/12, but a plan to promote healing and prevent additional pressure ulcers had not been developed by 7/12/12. At 10:40 AM on that date, the DON verified the care plans needed to be revised. 2. Review of the care plan for resident #43 showed it was 54 pages long, repetitious, and did not show the resident's current status. Interview with the MDS coordinator on 7/11/12 at 9:30 AM confirmed the care plan was too long to be usable, and it needed revision to accurately reflect the resident's independence.	F 280	for all residents and their current status. The IDT of the care plans will be in serviced on the importance of asking questions as to what interventions can be placed on identified problem areas. The IDT meets on a weekly basis, as residents come up for their annual or quarterly care plans, the current care plan will be updated to current status. The care plans for that week will be reviewed following day by MDS Coordinator and NHA or designee weekly until resolved and then quarterly thereafter.	9/30/12 8/26/12
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, review of medical records, and staff interview, the facility failed to maintain professional standards of practice related to clarification and/or transcription of orders and medication administration for 3 of 12 sample residents (#9, #22, #43). The findings were:	F 281	F281 The facility will provide professional standards of quality. A) Resident #43 will have her order for insulin clarified. This will be completed by ~~9/30/12~~ 8/26/12. All residents will have their orders clarified to ensure that there is no confusion. B) Resident #43 who was given a PRN of Tramadol will have documentation and the documentation will include the rationale for administration, the name of the	PP

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F 281	Continued From page 15 1. According to the "Physician Order Report" signed 7/5/12, resident #43 had four different orders for insulin: a. Insulin Aspart 1 to 4 units subcutaneously (subq) per sliding scale three times daily (tid) before meals in addition to the 5 units scheduled tid with meals. b. Insulin Aspart 5 units tid with meals. c. Lantus 20 units subq at bedtime. d. Novolog sliding scale insulin injections. The frequency of the sliding scale and injections was not specified. Further review showed the same orders had been present on the monthly order sheets since the resident's admission in May 2012. These orders had not been clarified in the two months they were on the record. Review of the July 2012 MARs showed the resident received the ordered prn (as needed) dose of Tramadol 50 mg once on July 3rd, 4th, and 6th and twice on July 8th and 9th. Further review showed the reasons for administering the medication and its effectiveness were not documented at all on July 3rd, 4th, and 6th and only once on July 8th and 9th. According to the DON on 7/11/12 at 10:53 AM, staff were to document administration of prn medications on the back of the MAR. This documentation should include the rationale for administration, the name of the medication, the amount administered, and its effectiveness. Observation on 7/11/12 at 4:56 PM showed RN #10 prepared Miralax for administration by pouring one ounce of the medication into a plastic medication cup. Review of the MAR showed the resident was to receive 17 grams. When questioned about this, the RN said staff had been preparing the medication in this manner for an	F 281	medication, the amount administered and its effectiveness. All residents will have documentation on all PRN medications and the documentation will include the rationale for administration, the name of the medication, the amount administered and its effectiveness. C) Resident #43 will receive the correct amount of Miralax. All residents will receive the correct dosage medication. D) Resident # 9 had been receiving the correct dosage of the 12.5 mg of Zoloft; but since it is not a regulation to have physician order report we will no longer have them in place. All residents will receive the correct dosage of medications. E) Resident #22 will receive the correct dosage of the Norco. The order was clarified and the order from 4/23/12 has now been noted and the order for 7.5/325 mg has been removed from the MAR. All residents will receive the correct dosage of medications and all orders will be clarified and noted. F) The physician order report will no longer be used in the facility since it is not a regulation to have. G) We have started the process of	

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F 281	Continued From page 16 unknown length of time since the bottle of Miralax no longer came with the clear plastic measuring cup marked with 17 grams. Review of the bottle cap with the RN showed a thicker, white cup inside the cap with 17 grams marked at the top of the cup. When the RN filled this cup and then poured it into the plastic medication cup, the amount of 17 grams was twice the amount originally prepared. This resident had been seen in the emergency department on 6/17/12 for complaints of constipation. 2. Review of the medication administration record showed 12.5 mg of sertraline HCL (Zoloft) was administered daily to resident #9. Review of the orders showed the dosage was changed from 25 mg to 12.5 mg on 3/29/12. However, review of all subsequent monthly "Physician Order Reports" from that date forward showed they still listed that 25mg of Zoloft be administered. The most current "Physician Order Report", with an effective date of 7/1/12, was signed by the physician on 6/7/12. The dosage discrepancy had not been clarified. 3. Review of the physician's orders signed 7/5/12 showed resident #22 had orders for both Norco 7.5/325 mg four times daily as needed for pain and hydrocodone (another name for Norco) 5/325 mg 1 or 2 tablets every four to six hours as needed for pain. The order for Norco 7.5/325 mg was dated 3/1/12 and the order for hydrocodone 5/325 mg was dated 4/21/12. Further review showed a note to the physician dated 4/22/12 requesting clarification as to which order was correct; the physician's response on 4/23/12 was "decreasing to 5/325." However, this order was never noted, and both remained on the signed MARs from April through July 2012.	F 281	going to EMARS which will help with our clarification process and residents receiving the correct dosages of medications. There will also be a double check put in place; meaning when the new MARS come in from pharmacy DON or designee will compare the updated MAR to current physician order. The comparisons will be done on a monthly basis and brought to QA monthly until the issue has been resolved and then quarterly thereafter. Nurses will be in serviced on the importance of all residents receiving the correct dosage of medications. Nursing staff will also be in serviced on the importance of documentation of PRN medications the documentation will include the rationale for administration, the name of the medication, the amount administered and its effectiveness. DON or designee will audit documentation on PRN medications on a monthly basis to ensure that it is being done and will bring to QA until resolved and then quarterly thereafter. Lastly nursing staff will be in serviced on clarification and noting physician orders and following up on requests. 9/30/12 9/30/12	

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F 281	Continued From page 17 4. On 7/10/12 at 4:30 PM the DON confirmed staff were to check the monthly "Physician Order Report" forms against the MARs to ensure the orders were correct and transcribed appropriately. She further stated "Evidently they aren't" comparing the two. Review of the order sheets showed neither nursing nor the pharmacist signed the "Physician Order Report" forms as reviewing the orders. References: According to Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills," Seventh Edition, 2008, p. 568, "If a written order is illegible or is questionable for any reason, the physician must be notified for clarification." Further review of the same page showed "...the nurse is responsible for validating, preparing, and administering medications safely..." Page 569 of the same reference itemizes the "Six Rights" of medication administration which includes the "Right dose." The Wyoming State Board of Nursing Rules and Regulations Chapter 3 Standard of Nursing Practice, Section 2. Standards of Nursing Practice for the Registered Professional Nurse (b) (i) The registered professional nurse: (G) Seeks clarification of orders when needed;	F 281		
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.	F 282		

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F 282	Continued From page 18 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 2 of 12 sample residents (#11, #19). The findings were: 1. Review of the 4/9/12 annual MDS assessment for resident #11 showed s/he was at risk for developing pressure sores. According to the care plan, the resident needed a pressure reducing cushion in the wheelchair. Periodic observations from 7/9/12 to 7/12/12 revealed the resident sat in the wheelchair without a cushion. During an interview on 7/12/12 at 2:30 PM, RN #12 confirmed the resident did not have a pressure relieving cushion in the wheelchair. At that time the nurse stated it should have been in the wheelchair because the resident needed it. 2. Review of the care plan, revised 4/2/12, for resident #19 showed the following interventions were to consistently be implemented by the nursing staff: a. Apply TED (compression) hose every morning and remove them at night. b. Reposition at least every two to four hours. c. Document preventive and treatment measures. d. Monitor and record skin status weekly. Observation on 7/10/12 revealed the TED hose had not been applied to the resident's legs from 7:30 AM until 12:45 PM. The observed bilateral lower extremity edema remained unchanged during this time. Observation on 7/10/12 from 8:20 AM until 12:45 PM revealed the resident sat in the recliner chair in his/her room without being	F 282	F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. A) Resident #11 will have a cushion placed in her wheel chair. All residents will have their care plans followed. B) Resident #19 will have TED (compression) hose applied every morning and removed every night. He/she will be repositioned every two to four hours. #19 will have documentation for preventive and treatment measures. He/she will have her skin status monitored and recorded weekly. All residents will have their care plans followed. C) All nursing staff will be in serviced on the importance of following the care plan. An audit of care plans will be done on a monthly basis by MDS nurse or designee to ensure that we are following care plan properly. This audit will be brought to QA until the problem is resolved and then quarterly thereafter.	9/30/12 8/21/12

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F 282	Continued From page 19 repositioned by staff. Review of the April, May, June and July preventive skin care monitoring and assessment documentation showed weekly documentation and monitoring to address the pressure ulcer on the resident's coccyx area had not been done. In an interview on 7/11/12 at 5:05 PM, the MDS coordinator stated all of the care plan interventions for this resident were current and applicable and should be consistently followed.	F 282		
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on review of medical records and staff interview, the facility failed to provide the required discharge summaries for 2 of 2 sample residents (#54, #55) for whom discharge was anticipated. The findings were: 1. According to the 4/24/12 social worker's notes, resident #54 was transferred to another facility on that date. However, the notes were not included in the resident's closed medical record. In addition, review of the medical record showed a recapitulation of stay was lacking. On 7/12/12 at 10:25 AM the manager of the medical record	F 283	F283 The facility will provide a discharge summary that includes a recapitulation of the resident's stay and a final summary of the resident's status at the time of discharge. A) Discharge summaries will be done for residents #54 and #55. When a resident is being discharged there will be a discharge summary done by the appropriate disciplinarians. B) The interdisciplinary involved in the discharge planning will be in-serviced on what needs to be done when a resident is being transferred. All discharges will be evaluated on a monthly basis by Social Service or designee to ensure that a discharge summary had been done and brought to QA on a monthly basis until resolved and then bi-yearly thereafter.	9/30/12

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F 283	Continued From page 20 department stated she was unaware the recapitulation of stay form was needed. She confirmed the it had not been completed. 2. Review of the medical record showed a discharge summary for resident #55 was lacking. Interview with the DON on 7/12/12 at 8:40 AM confirmed the discharge summary had not been completed.	F 283		
F 284 SS=E	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop the required post-discharge plan of care for 2 of 2 sample residents (#54, #55) for whom discharge was anticipated. The findings were: Review of the medical records for residents #54 and #55 showed a post-discharge plan of care was not developed for either resident. There was a discharge summary for resident #54, but it failed to include a post-discharge plan of care. At 9:40 AM on 7/12/12 the social work confirmed her documentation did not contain a post-discharge plan of care for resident #54. A discharge summary was lacking for resident #55. At 8:40 AM on 7/12/12 the DON confirmed there was no	F 284	F284 The facility will have a discharge summary that includes a post-discharge plan of care that will be developed with the participation of the resident and his or her family. A) Residents #54 and #55 will have a post discharge plan of care. All residents who are discharged will have a post discharge plan of care including the participation of the resident and his/her family. B) The interdisciplinary involved in the discharge planning will be in serviced on what needs to be done when a resident is being transferred. All discharges will be evaluated on a monthly basis by Social Service or designee to ensure that a discharge summary had been done and brought to QA on a monthly basis until resolved and then bi-yearly thereafter.	9/20/12 8/20/12

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F 284	Continued From page 21 discharge plan, discharge order or summary, or nursing/social service documentation related to discharge for resident #55.	F 284	F309 The facility will proved the necessary care and services to attain or maintain	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to provide necessary care and services for 2 of 12 sample residents (#19, #43). The findings were: 1. Review of the 5/17/12 pain assessment showed resident #43 had chronic, daily pain, but the 5/22/12 admission MDS assessment documented the resident had moderately severe occasional pain. During an interview on 7/9/12 at 4:15 PM, the resident stated s/he had a rod in his/her back and pain was not controlled. The resident further stated breakthrough pain was treated with Tylenol, which was effective for about 45 minutes and then s/he could not have more for three more hours. Review of the medical record showed the resident had had back surgery and had a diagnosis of chronic back pain. Review of the physician's orders showed multiple medication changes had been attempted to	F 309	the highest practicable physical mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A) Resident # 43 will have her pain controlled. All residents with any pain will have their pain controlled. The documentation for a PRN will have documentation and the documentation will include the rationale for administration, the name of the Medication, the amount administered and its effectiveness for resident #43 and all residents. B) Resident # 19 will have her TED hose applied in the morning and taken off at night. There will be more than one pair of TED hose ordered. All residents will have all the necessary care and services to attain or maintain the highest practicable physical meant and psychosocial well being. C) Nursing staff will be in serviced on the importance of documentation of PRN medications the documentation will include the rationale for administration, the name of the medication, the amount administered	

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F 309	Continued From page 22 control pain, and the resident routinely received Neurontin with Tylenol every 4 hours prn and Tramadol twice daily prn for breakthrough pain. Review of the July 2012 MARs showed the resident received the prn dose of Tramadol 50 mg once on July 3rd, 4th, and 6th and twice on July 8th and 9th. Further review showed the reasons for administering the medication and its effectiveness were not documented on July 3rd, 4th, and 6th and only once on July 8th and 9th. According to an interview with the DON on 7/11/12 at 10:53 AM, staff were to re-assess residents after administration of each prn medication to determine its effectiveness. 2. According to the medical record for Resident #19, the physician ordered TED (compression) hose to be worn daily to treat lower extremity edema. Review of the care plan, revised 4/2/12, showed staff were to apply TED hose every morning and remove them at night. Observation on 7/10/12 revealed the TED hose had not been applied to the resident's legs from 7:30 AM until 12:45 PM. The observed bilateral lower extremity edema remained unchanged during this time. Interview with RN#12 on 7/10/12 at 4 PM revealed the TED hose had not been applied that day because they were washed and hanging to dry. At that time the RN stated she did not know why only one pair had been ordered instead of two pairs.	F 309	and its effectiveness. DON or designee will audit documentation on PRN medications on a monthly basis to ensure that it is being done and will bring to QA until resolved and then quarterly thereafter. Nursing staff will be in serviced on providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychotically well being, in accordance with the comprehensive assessment and plan of care; an audit of this will be done on a monthly basis by MDS coordinator or designee and brought to QA on a monthly basis until resolved and then quarterly thereafter.	9/30/12 8/26/12
F 314 SS=D	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	F 314		

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F 314	Continued From page 23 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 2 of 6 sample residents (#19, #23) who were at risk for developing pressure ulcers. The findings were: Review of the 12/20/11 admission, 3/12/12 quarterly, and 5/11/12 significant change MDS assessments showed resident #19 was at risk for developing pressure ulcers. Review of the 5/11/12 significant change MDS assessment showed the resident was totally dependent on staff for transfers and bed mobility, and had moisture associated skin damage. Review of the care plan, updated on 6/18/12, showed interventions that addressed the risk for impaired skin integrity included: "Document preventive and treatment measures and description of lesions ... if lesion or denuded area present. Monitor and record skin status weekly ... Reposition at least q [every] 2 to 4 hours and prn [when necessary] if resident unable to perform on own." Review of the nurses' notes showed staff first noted an "open area to buttocks" on 4/17/12. Review of the 7/10/12 non-pressure skin condition record showed the area on the buttocks/coccyx had deteriorated and the wound bed was dark pink, excoriated, and	F 314	F314 The facility will 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. A) Resident #19 will have proper documentation and consistent treatment concerning her impaired skin integrity. All residents will have proper documentation and consistent treatment to any impaired skin integrity issues. 1) Nurses notes will be done weekly on skin assessments and treatment and will reflect what and when treatments were applied for resident #23 and all residents. 2) The monitoring system will include information regarding how long the same treatments were implemented and which treatments and interventions were effective. Monitoring will be consistent and there will be only one monitoring tool being utilized for resident #19 and all residents.	

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F 314	Continued From page 24 macerated. This review also showed the area measured 8 by 3.3 centimeters. Observation on 7/10/12 at 2:15 PM revealed the MDS coordinator, the DON, and physical therapist #3 removed the dressing on the resident's coccyx area and exposed a stage II open, moist pressure ulcer that appeared as documented on the 7/10/12 non-pressure skin condition record. The following concerns were identified: a. Review of the nurses' notes, weekly skin assessments, and treatment records showed, that since the area was first identified on 4/17/12, staff had failed to assess and document the appearance of the area every week. There was also a lack of documentation show what and when treatments were applied. b. Review of the monitoring system showed it did not include information regarding how long the same treatments were implemented and which treatments and interventions were effective. Review of this system also showed monitoring was inconsistent and two different monitoring tools were being utilized at various times. Further review showed at times the same area was assessed as a pressure ulcer and at other times it was assessed as a non-pressure area. c. Interview with the MDS coordinator on 7/12/12 at 1 PM revealed the lack of an effective, consistent assessment and monitoring system made it difficult to determine what factors contributed to deterioration in the pressure ulcer. d. Observation on 7/10/12 from 8:25 AM to 12:45 PM revealed the resident sat in the recliner chair continuously without repositioning. 2. According to the 6/6/12 quarterly MDS assessment, resident #23 was at risk for	F 314	3) An effective and consistent assessment and monitoring system will be put in place for resident #19 and all residents. 4) Resident #19 will be repositioned every 2 to 4 hours or as needed for resident #19 and all residents. B) Resident #23 will have proper documentation and consistent treatment concerning her impaired skin integrity. All residents will have proper documentation and consistent treatment to any impaired skin integrity issues for resident #19 and all residents. 1) There will be documentation on a weekly basis done on skin integrity by CNA's for resident #23 and all residents. 2) An effective and consistent assessment and monitoring system will be put in place for resident #23 and all residents. 3) Resident #23 will have proper documentation and consistent treatment concerning her impaired skin integrity. All residents will have proper documentation and consistent treatment to any impaired skin integrity issues for resident #19 and all residents.	

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F 314	Continued From page 25 developing pressure ulcers. Observation on 7/10/12 at 3 PM showed the resident had a Stage II pressure ulcer with a center area of yellowish slough on the right buttock. At that time, both physical therapist #3 and the MDS coordinator stated the wound had improved. Measurements of the wound were 2.5 cm by 1.6 cm with the area of slough measuring 0.8 cm by 0.7 cm. The resident had been hospitalized on 7/3/12 and returned to the facility on 7/9/12. The following deficient practice related to lack of monitoring and documentation was identified: a. Review of the 6/8/12 CNA checklist showed the resident had a Stage II pressure ulcer on the left buttock. On 6/22/12 the CNA checklist documentation showed "2 sores on [his/her] bottom" written beside the area for coccyx and "sore behind ear from glasses" was written by the space labeled "Behind ears." There was no CNA documentation between 6/8 and 6/22/12 or after 6/22/12. b. Review of nursing documentation dated 6/12/12 showed "Resident seen for wound rounds. Refused care from...Will reapproach in one week. CNA's to report to nurse if resident will allow assessment." There was no documentation describing the wound from 6/8/12 until 6/22/12, a total of 14 days. Nursing documentation dated 6/22/12 showed a "2.8 X 1.8 area noted on ischium cleaned [with] wound cleanser covered [with] dimethecone [and] Island dressing. Stage 1 (one). Will monitor." There was no other descriptive documentation until 6/26/12 to show whether the wound was improving. c. According to the 6/26/12 narrative wound rounds documentation, the left ischium was healing well and treatment was discontinued. Further review showed "Noted area on coccyx.	F 314	C) All charge nurses will be attending a wound care/pressure ulcer boot camp on 8/1/2012. A new wound care system will be developed and implemented. Wounds will be discussed on a weekly basis after wound care team sees the wounds. All documentation will be reviewed at that time, it will be brought to QA on a monthly basis until there are no more issues and then quarterly thereafter.	9/30/12 8/21/12

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F 314	Continued From page 26 Reddened area...Superficial Blanched...Will monitor..." There was no specific documentation in the nursing narrative to show if the area on the coccyx was open, what treatment was initiated, or the appearance of the wound. However, review of the "Pressure Ulcer Healing Chart" dated 6/22/12 showed documentation dated 6/26/12 of an ulcer located on "Right Buttock/Left Buttock" that measured 2.1 cm by 1.1 cm with slough tissue but no exudate. The facility was unable to explain the discrepancy in the dates. d. The form entitled "Non-Pressure Skin Condition Record" indicated the resident had a pressure ulcer first observed on 6/26/12 and dietary was notified on that date. The only other documentation was dated 7/10/12 and showed measurements of 2.5 cm by 1.6 cm by 0 cm with no tunneling or undermining present. The wound was described as partial thickness, with pink, pale tissue in the wound bed and a scant amount of serous drainage; an area of slough located in the center of the wound was documented as measuring 0.8 X 0.2 cm. There was no documentation to show whether the wound was open on 6/26/12. e. On 7/12/12 at 1 PM the DON, physical therapist #3 and the MDS coordinator stated they were unaware the two forms they were using for documentation were for different types of wounds. They also acknowledged better documentation was needed. 3. Review of the wound and skin care protocols, dated November 2010, showed procedural requirements included "monitor and evaluate the effectiveness of the care provided daily and make changes as needed. If the ulcer fails to show evidence of healing progress within 7-10 days,	F 314		

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F 314	Continued From page 27 reassess the ulcer and ... overall condition." F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER SS=D Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure 1 of 8 (#15) residents with incontinence received appropriate treatment and services to maintain normal bladder function and prevent urinary incontinence. The findings were: Review of the 5/11/12 significant change MDS assessment for resident #15 showed s/he was frequently incontinent of urine and required total assistance with toileting and personal hygiene care. Review of the corresponding care plan showed interventions that addressed toileting and personal hygiene needs were lacking. Toileting assistance was not provided during the following continuous observations on 7/10/12 from 7:15 AM to 1:10 PM: a. The resident was eating breakfast in the dining room at 7:15 AM and received 80 mg of Lasix (a diuretic) at 8 AM.	F 314 F 315	F315 The facility will ensure that a resident who enters the facility without an indwelling catheter is not catherized unless the resident's clinical condition demonstrates that the cathertization 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. A) Resident #15 and all residents will have care plans that include interventions addressing toileting and personal hygiene needs. Care plans will be reviewed on a quarterly basis for each resident. A more critical way of thinking will be looked at. The care plans will be reviewed weekly after care plan day. Then taken to QA monthly until all issues have been resolved and quarterly thereafter. 1) Resident #15 will be toileted every two hours or as needed. 2) All residents will be toileted every two hours or as needed.	PT 8/24/12

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F 315	Continued From page 28 b. At 8:20 AM CNAs #5 and #2 transferred the resident from the wheelchair to the recliner chair in his/her room. c. The resident remained in the recliner chair until 10:20 AM, when s/he was wheeled to the beauty shop. d. At 11:55 AM the resident was wheeled to the dining room for lunch. e. At 1:10 PM, 5 hours and 10 minutes after receiving Lasix, CNAs #5 and #2 assisted the resident to the bathroom and removed the urine soiled disposable brief before they positioned him/her on the bathroom commode. At 1:10 PM CNA #2 stated the usual routine of toileting the resident every two to three hours had been disrupted this day because the resident had an extended appointment at the beauty shop. In an interview on 7/12/12 at 1:30 PM the resident described her attempts to "hold it" when staff were unable to provide toileting assistance in a timely manner as, "I have learned to wiggle a lot, but it doesn't always work."	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of internal audits and minutes of the	F 323	F323 The facility will ensure that the resident's environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. A) Resident #23 and resident #48 will have all interventions that are placed in fall committee will be placed in the care plan. All residents who have had falls will be reviewed at fall committee and interventions put in place at that time will be added to the care plan then as well. B) The MDS coordinator will start attending the fall committee meetings	

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F 323	Continued From page 29 "Fall Committee" meetings, the facility failed to provide adequate supervision, interventions, and monitoring to prevent falls for 1 of 6 sample residents (#23) at risk for falls. The findings were: 1. Review of the 12/7/11 annual and 6/6/12 quarterly MDS assessments showed resident #23 had sustained several falls, some with minor injuries. Review of the 4/2/12 fall risk assessment showed the resident was at high risk for falls. According to nursing documentation, the resident fell on 6/2, 6/19, and 6/30/12. Review of the "Incident Report Audit" confirmed this information. However, review of the care plan showed the interventions remained unchanged since originally developed on 7/20/11. On 7/12/12 at 10:48 AM the DON stated the "Fall Committee" met weekly, analyzed the resident's falls, and developed interventions. However, these new interventions were not added to the care plan, and there was no monitoring to ensure they were implemented. 2. Review of the "Fall Committee" minutes with the DON on 7/12/12 at 10:48 AM confirmed the committee met weekly, reviewed all falls, and developed new interventions for each resident. When asked how staff were notified of the new interventions, the DON replied that they were discussed at the monthly staff meetings attended by most CNAs. However, since the interventions were not entered in the care plans, the DON acknowledged there was no way to ensure the new interventions were implemented for residents who fell right after the last staff meeting. Further, she confirmed the lack of monitoring to determine the effectiveness of the interventions. According to the "Incident Report Audit" from 6/2/12 through	F 323	so that the interventions can be added at that time to the chart. C) Fall committee will continue to be held weekly and attendees will be admin., DON, M.R. and MDS coordinator. Medical records will post any new interventions at nurse's station so that all nursing staff is aware of changes. Monthly audits will be done on interventions that they are being initialized and then continued. The audits will be done by Medical Records or designee and will be brought to QA on a monthly basis until resolved and then quarterly thereafter.	9/30/12 8/20/12

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F 323	Continued From page 30 7/8/12, resident #48 fell 4 times, two discharged residents each fell 3 times, and fourteen other residents fell once.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain an observed medication error rate under 5 percent (%). Out of 40 opportunities for errors, 2 observed errors were committed, resulting in an error rate of 5%. The residents effected by these errors were sample residents #22 and non-sample resident #27. The findings were: 1. Observation on 7/9/12 at 5:20 PM showed LPN #7 reviewed the blood glucose level of resident #22 and stated she needed to draw up 6 units of Novolog insulin per the sliding scale order as well as the 12 units the resident routinely received before meals. Review of the MAR verified the dose the LPN said was needed. After preparing the insulin, the LPN checked the amount in the syringe and stated it was 18 units. Observation of the syringe showed the actual amount of insulin in the syringe was 20 units. When questioned, the LPN rechecked the syringe and confirmed she had prepared 20 units of insulin that she was planning to administer until the surveyor intervened. Reconciliation of the medication pass with the physician's orders confirmed the resident	F 332	F332 The facility will ensure that it is free of medication error rates of five percent or greater. A) Resident #22 will receive the correct dosage of insulin as well as the rest of the residents. The LPN # 7 and the rest of the nurses will be in serviced on the proper techniques in drawing up insulin. B) There will be periodic monthly audits on proper dosage of medications done on a monthly basis. The audits will be done my DON or designee and brought to QA on a monthly basis until resolved and then quarterly thereafter. C) Resident #12 and all other residents will have orders for medication given. D) We have started the process of going to EMARS which will help with our clarification process and ensuring that the MARS are matching the physician orders. There will also be a double check put in place; meaning	

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	535040	A. BUILDING _____ B. WING _____	C PP 07/12/2012

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F 332	Continued From page 31 should have received 18 units of Novolog insulin. 2. Observation on 7/9/12 showed RN #12 instilled two drops of Systane ophthalmic drops into both eyes of resident #27. Reconciliation of the medication pass with the "Physician Order Report", signed by the physician on 6/6/12, revealed an order for Systane ophthalmic drops was lacking. On 7/10/12 at 10:16 AM, the DON confirmed the order had been missing on the "Physician Order Report" forms since February 2012.	F 332	when the new MARS come in from pharmacy DON or designee will compare the updated MAR to current physician order. The comparisons will be done on a monthly basis and brought to QA monthly until the issue has been resolved and then quarterly thereafter. Nurses will be in serviced on the importance of all residents receiving the correct dosage of medications.	9/30/12
F 353 S8=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	F353 The facility will have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. A) We do not believe that we are not adequately staffed but that we need to work with our staff to be more productive. Essentially work smarter not harder. B) We do advertise in our local and area news papers and online. We also hold CNA class's every six months or so. C) CNA's will be in serviced on the importance of their documentation on	9/30/12 10/24/12

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F 353	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interviews, review of the resident council minutes, and review of the nursing schedule, the facility failed to consistently ensure adequate staff were assigned to provide care for the residents. The findings were: 1. Confidential interviews between 7/11/12 and 7/12/12 with three licensed nurses and three CNAs revealed there was a lack of sufficient staff. All stated the number of staff to meet the residents' needs in a timely manner during the day and evening shifts should include at least two CNAs for each of the three nursing units (A, B, and C halls). They stated the non-certified "helping hands" staff were helpful but they were not scheduled every day and they were unable to provide direct care. They also stated the lack of sufficient staff affected the residents in the following manner: a. The response to the call lights was delayed. b. The meal service was untimely. c. Showers, scheduled two to three times per week, were omitted. c. If a resident required close one to one monitoring, staff were unable to provide this type of vigilance. d. Because the nurses were required to work on the nursing units, they were unable to complete the required MDS assessments. 2. Review of the 4/26/12 resident council meeting minutes revealed resident concerns included slow meal service time and slow responses to call lights. Review of the 5/31/12 resident council	F 353	bathing of residents. D) Residents will receive baths on their scheduled days on a consistent basis. E) The DON or designee will do monthly audits of the bathing schedule to ensure that all residents are receiving their baths and that there is documentation to support it. The audits will be brought to QA monthly until resolved and then quarterly thereafter. 9/30/12 F) F 50 is a long way. 9/26/12 RN or designees will monitor acuity monthly make changes in staffing patterns accordingly. MDS nurses have be reassigned duties to allow time for working with MDSs. The nurses also have attended an MDS training. PP	

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F 353	Continued From page 33	F 353		

meeting minutes revealed the residents continued to have concerns about the slow response to call lights. Review of the 6/28/12 resident council meeting revealed the residents verbalized their concerns about the lack of CNAs.

3. In an interview on 7/9/12 at 3:45 PM, resident #19's family member stated various members of the family tried to schedule visits to ensure they were present during meal times. This family member stated that in addition to their desire to assist the resident, they felt they were helping the staff who worked hard but could not get to all the residents. On 7/12/12 at 11:30 AM, CNA #5 revealed the CNAs documented in the bath log when showers were provided, the condition of the resident's skin at that time and when the residents refused an offered, scheduled shower. Review of the June and July 2012 bath log for four randomly selected sample residents showed the four resident did not consistently receive showers/baths two to three times weekly. Review of the bath log showed in June, resident #11 refused one time and received six showers. However the resident had only received one shower in July with no documented refusal. Resident #15 received four showers in June and two in July with no documented refusals. Resident #19 received four showers in June with no documented refusals. Resident #38 received one shower in July and refused once. In an interview on 7/17/12 at 8:45 AM resident #50's friend stated she visited frequently, and in the past two weeks s/he has become upset by the resident's appearance and odors that indicated the lack of bathing and personal hygiene care.

4. During an interview on 7/12/12 at 11:35 AM,

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F 353	Continued From page 34 the DON stated they made sure there were two CNAs on duty on the C hall, but the other two halls were divided among three CNAs. She acknowledge the additional CNA would be "ideal" at times when the acuity was higher, but the facility did not have sufficient staff to accommodate that need, and during those times care was not provided in a timely manner. Review of the June and July day shift nursing schedules with the DON on 7/12/12 at 11:36 AM revealed there were two days in June and one day in July when less than five CNAs were scheduled, only one day in each month when six CNAs were scheduled, and the remaining days for each month showed five CNAs were scheduled.	F 353		
F 428 SS=E	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 by: Based on medical record review, staff interview, and review of the pharmacy consultant reports, the facility failed to ensure the medications listed on the monthly "Physician Order Report" were accurate for 4 of 12 sample residents (#9, #22, #32, #43). The findings were:	F 428	F428 The drug regimen of each resident will be reviewed at least one a month by a licensed pharmacist. A) Resident #43 will have the frequency of the sliding scale and injections specified. All residents will have the frequency of the sliding scale and injections specified. B) Resident #22 will receive the correct dosage of the Norco. The order was clarified and the order from 4/23/12 has now been noted and the order for 7.5/325 mg has been removed from the MAR. All residents will receive the correct dosage of medications and all orders will be clarified and noted. C) Resident # 9 had been receiving	

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F 428	Continued From page 35 1. According to the "Physician Order Report" signed 7/5/12, resident #43 had four orders for insulin: a. Insulin Aspart 1 to 4 units subcutaneously (subq) per sliding scale three times daily (tid) before meals in addition to the 5 units scheduled tid with meals. b. Insulin Aspart 5 units tid with meals. c. Lantus 20 units subq at bedtime. d. Novolog sliding scale insulin injections. The frequency of the sliding scale and injections was not specified. Further review showed the same orders had been present on the monthly order sheets since the resident's admission in May 2012. Review of the pharmacist's reports showed no evidence these discrepancies were identified as irregularities. 2. Review of the physician's orders signed 7/5/12 showed resident #22 had orders for both Norco 7.5/325 mg four times daily as needed for pain and hydrocodone (another name for Norco) 5/325 mg 1 or 2 tablets every four to six hours as needed for pain. The order for Norco 7.5/325 mg was dated 3/1/12 and the order for hydrocodone 5/325 mg was dated 4/21/12. Further review showed a note to the physician dated 4/22/12 requesting clarification as to which order was correct; the physician's response on 4/23/12 was "decreasing to 5/325." However, this order was never noted, and both remained on the signed "Physician Order Report" forms from April through July 2012. Detailed record review showed no evidence the pharmacist identified these medications as irregularities. 3. Review of the medication administration record	F 428	the correct dosage of the 12.5 mg of Zoloft; but since it is not a regulation to have physician order report we will no longer have them in place. All residents will receive the correct dosage of medications. D) Resident #32 was receiving the correct orders of synthroid. We will discontinue the use of the physician order report. E) We have started the process of going to EMARS which will help with our clarification process and residents receiving the correct dosages of medications. There will also be a double check put in place; meaning when the new MARS come in from pharmacy DON or designee will compare the updated MAR to current physician order. The comparisons will be done on a monthly basis and brought to QA monthly until the issue has been resolved and then quarterly thereafter.	9/30/12 8/24/12

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F 426	Continued From page 36 showed 12.5 mg of sertraline HCL (Zoloft) was administered daily to resident #9. Review of the monthly pharmacy drug regimen review showed the dosage was changed from 25 mg to 12.5 mg on 3/29/12. However, review of all subsequent, signed, monthly "Physician Order Report" forms from that date forward showed Zoloft 25 mg was still listed for administration. The most current "Physician Order Report" with an effective date of 7/1/12 was signed by the physician on 6/7/12. 4. Review of the medication administration record showed 175 micrograms (mcg) of thyroid medication was administered daily to resident #32. Review of the monthly pharmacy drug regimen review showed the dosage was reduced from 200 mcg (initially listed as synthroid) to 175 mcg (currently listed as levothyroxine) on 2/27/12. Review of all monthly "Physician Order Report" forms from that date through the most current one showed both levothyroxine 175 mcg and synthroid 200 mcg were listed for administration. Interview with RN #8 on 7/10/12 at 10:48 AM revealed she did not know why both entries were still listed on the monthly physician order reports. 5. During an interview on 7/16/12 at 9:53 AM, pharmacist #11 stated pharmacy prepared the MARs and they were correct. However, she did not know why the medications were not identified as irregularities. She stated she would check for additional information related to identification of these medications as irregularities and send it if found; no information was received from the pharmacist by 7/20/12.	F 426		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 37 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	F441 The facility will 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) Resident #22 and all of the residents who use the glucometer will have the glucometer wiped and maintain a continuous wet contact time of two minutes or adhere to the manufactures instructions on the container of wipes. B) Nurses will be in serviced on the proper cleaning of the glucometer. Periodic monthly audits will be done by the DON or designee to ensure that the cleaning is done correctly. The audits will be brought to QA on a monthly basis until the issue is resolved and then quarterly thereafter.	9/30/12 8/20/12

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F 441	Continued From page 38 by: Based on observation, staff interview, and review of manufacturer's instructions, the facility failed to ensure compliance with infection control practices. This lack of compliance involved failure to clean a glucometer, a point of care device, after 1 of 1 observations of use for resident #22. The findings were: Observation on 7/9/12 at 5:37 PM showed LPN #7 wiped off the glucometer after obtaining a blood sample from resident #22. The LPN used a "Super SaniCloth" for wiping the meter but did not maintain a continuous wet contact time. She then placed the meter in a drawer on the medication cart. On 7/10/12 at 4:10 PM, RN #12 stated she had also wiped off the glucometer without maintaining a continuous wet contact time. She further stated she knew of the time requirement but did not always adhere to it. Review of the manufacturer's instructions on the container of wipes showed a two minute continuous wet contact time was required for disinfection.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 1 waterless food warmers in a safe operating condition. The findings were:	F 456	F456 The facility will maintain all essential mechanical, electrical and patient care equipment in safe operation condition. A) A new waterless food warmer will be purchased.	9/30/12 8/24/12

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F 456	Continued From page 39 Observations on 7/9/12 at 5:30 PM and 7/12/12 at 10:30 AM revealed the waterless food warmer used by kitchen staff to maintain food temperatures while serving had a broken heating plate. The flat plate, approximately 12 inches x 17 inches, transferred the source of heat (natural gas) to the underside of pans containing resident food. The center of the plate had burned through, and the flame from the ignited gas was directly heating the food pan. Interview with the kitchen manager on 7/12/12 at 9:48 AM revealed she was aware the heating element cover plate had burned through, but the facility had not yet purchased a new food warmer.	F 456		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for facility staff in one of three soiled utility linen closets. The findings were: Observation of the soiled utility linen closet across the hall from resident room #101 on 07/09/12 at 3:48 PM and then again on 7/10/12 at 12:46 PM revealed five small, red, unsecured, biohazardous bags sitting on top of a hazardous trash container. Each bag contained a full, hard, plastic, sharps container. Instructions for proper disposal of full hazardous bags were posted on	F 465	F465 The facility will provide a safe, functional sanitary and comfortable environment for residents, staff and the public. A) All full bags will be placed in a large cardboard box lined with another large, red, hazardous bag. The large, red liner bag and cardboard box are then to be taped shut prior to being picked up by the biohazardous waste disposal staff. B) Staff will be in serviced on the instructions of biohazard material in accordance with the instructions. This will be monitored by Maintenance or designee on a bi-weekly basis and brought to QA monthly until resolved and then quarterly thereafter.	9/30/12 8/24/12

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F 465	Continued From page 40 the wall next to the bags. Directions indicated each full bag was to be placed in a large cardboard box lined with another large, red, hazardous bag. Both the large, red liner bag and the cardboard box were then to be taped shut prior to being picked up by the biohazardous waste disposal staff. Interview with the DON on 7/12/12 at 10:46 AM revealed the small, individual hazardous waste bags containing the sharps containers represented a safety hazard to staff who came into the room in the event one of the bags fell onto the floor. She stated each bag should be placed in the cardboard box as soon as the sharps container was placed in it.	F 465		
F 503 SS=E	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this	F 503	F503 A) All glucometer strips when opened will have the expiration date wrote on them when they are opened. The nursing staff will monitor that the strips are never used after the 90 days after being opened. B) Nursing staff will be in serviced on the manufactures instructions on expiration dates. C) DON or designee will monitor on a monthly basis that expiration dates are being marked on the bottle of glucometer strips when they are opened. The audit will be brought to QA monthly until resolved and then quarterly thereafter.	9/30/12 9/26/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 07/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1105 BIRCH STREET DOUGLAS, WY 82633

(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 503	Continued From page 41 chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's instructions, the facility failed to ensure laboratory tests that utilized glucometer testing supplies were completed according to the regulatory requirements in Part 493. The findings were: On 7/9/12 at 7:15 PM LPN #7 was observed to open a new container of glucometer strips. At that time the LPN confirmed the container was unopened. Review of the label on the container showed a blank line after the words, "Expiration Date." Further review of the manufacturer's instructions showed the strips were only good for 90 days after the container was opened. Observation at 5:20 PM showed the LPN placed the opened container in the medication cart drawer without writing the expiration date on it. On 7/10/12 at 6:08 PM RN #12 was observed to hand an opened container of glucometer strips to another nurse. Review of the container at that time showed it also lacked the expiration date after being opened. RN #12 stated it was unknown when the strips were opened. She confirmed they were for resident use. Part 493 states waived tests must be performed according to the manufacturer's instructions.	F 503		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

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DOUGLAS CARE CENTER LLC	1100 BIRCH STREET DOUGLAS, WY 82633

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F 520	Continued From page 42 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the Quality Assurance (QA) program, the facility failed to maintain an effective QA program capable of identifying, evaluating, and resolving deficient practice issues. In addition, the facility failed to demonstrate sustainability of past actions implemented to resolve prior deficiencies. The findings were: The QA program was reviewed with the administrator on 7/12/12 at 1:37 PM. The administrator stated, and review of the program confirmed, that indicators were all the deficiencies	F 520	F520 The facility will maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility and at least 3 other members of the facility staff. A) The QA process will be revamped. There will continue to be monthly QA meetings held. We will also have an outside contractor to come through to audit our QA program to ensure that the program is operating in the manner that it should and issues are being resolved in a timely fashion. 9/30/12 8/20/12	

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DOUGLAS CARE CENTER LLC	1168 BIRCH STREET DOUGLAS, WY 82633

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F 520	Continued From page 43	F 520		

cited during last year's survey. However, the administrator was unable to show evidence indicators defining specific problems were clearly identified or that distinct, attainable goals (benchmarks) had been established. In addition, clearly defined action plans were lacking for most problems so that results provided insufficient information, or information that was useless for resolving the specific problem. Furthermore, there was no evidence results had been evaluated and tracked or that action plans were revised and implemented for those projects showing poor results. Finally, sustainability of resolutions was not demonstrated. During the review, the administrator acknowledged the QA program had been ineffective in resolving concerns identified during previous surveys.

Failure to identify quality of care deficiencies prior to the survey were identified as follows:

a. Refer to F309 for details related to pain and personal care. This deficiency was cited in 3/4 previous surveys.

b. Refer to F314 for information related to lack of effective monitoring and documentation of pressure ulcers. This deficiency was cited in 2/4 previous surveys.

c. Refer to F332 for information related to medication errors, cited in 2/4 previous surveys.

Deficiencies demonstrating lack of sustained QA resolutions included the following:

a. F272, cited in 3/4 of the last surveys
b. F274, cited in 3/4 previous surveys.
c. F278, cited in 3/4 previous surveys.
d. F279, cited in 2/4 of the last surveys.
e. F280, cited in 2/4 prior surveys.

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F 520	Continued From page 44 f. F281, cited in 2/4 previous surveys. g. F441, cited in 3/4 previous surveys.	F 520		