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

PRINTED: 11/02/2010
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
	535021	A. BUILDING Division of Healthcare Licensing and Surveys B. WING	C 10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide MDS- Minimum Data Set TB- Tuberculosis Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	F151 The facility will ensure residents have the right to access their personal belongings. This will be accomplished by:	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure the right to access personal belongings was protected for 1 of 12 sample residents (#41). The findings were: Observation on 10/12/10 at 11:55 AM revealed resident #41 had a hinge and padlock on the outside of his/her door, that was locked while the resident ate at a dining table outside the room. Interview with the south unit manager on 10/14/10 at 8:50 AM revealed the lock was used during meal times to keep the resident from taking food and drinks into his/her room. The manager revealed the resident made a mess with food and drinks and created a fall risk to him-/herself. The	F 151	1) The hinge and padlock were removed from the door of resident #41. 2) A policy and procedure for resident safety issues will be developed. The policy and procedure will include assessment, resident and/or resident family/guardian notification and consent. 3) Nursing staff will be in-serviced on the policy and procedure. 4) Unit coordinators to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010 11/30/2010 11/30/2010

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

x Anita Cox-Mills | x RN AHA Facility Manager | 11/15/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 151	Continued From page 1 manager stated this had been the facility's practice for at least the past six months. Review of the 7/16/10 social service quarterly progress note showed the resident's behaviors were "easily redirected with the correct approach." However, the same progress note showed the room door continued to be closed and locked during meals so that the resident does not take food and drink into the room and "make a mess." Interview with the south unit manager on 10/14/10 at 10:05 AM revealed she was unsure of what other approaches were tried prior to locking the door to keep the resident from making a mess in the room. She further verified she could not find any documentation to show resident's rights were taken into consideration or that this was the least restrictive method related to protecting the resident's rights.	F 151		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		

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F 157	Continued From page 2 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to notify the physician of 1 of 5 sample residents (#55) who experienced a significant change in condition. The findings were: Refer to F325 for details regarding the facility's failure to notify the physician of a significant weight loss for resident #55.	F 157	F157 The facility will ensure that the resident's physician is notified when there is a significant change in the resident's physical, mental, or psychosocial status. This will be accomplished by: 1) Resident #55 has gained weight and is now eating on the South unit so s/he can be better monitored. 2) Nursing staff will be In-serviced on the procedure of notifying the physician when there is a significant change in the resident's physical, mental, or psychosocial status.	11/30/2010 11/30/2010
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure	~~F 248~~	3) Unit coordinators to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/30/2010

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F 248	Continued From page 3 Individualized and meaningful activities were provided for 1 of 12 sample residents (#18). The findings were: Review of the activity assessment for resident #18 showed s/he enjoyed music, reading, movies, social events and being wheeled indoors. The following concerns were identified: a. Periodic observations from 10/11/10 through 10/13/10 showed the resident did not participate in any meaningful activities. The only observed activity was when staff sat him/her in front of the television on 10/12/10 at 7:15 AM after breakfast where the resident sat with his/her eyes closed and looked to be asleep. b. Review of the care plan for activities showed the following activities were identified as interventions: music, reading and writing, spiritual, walking-wheeling outdoors, television, conversation, and visiting. All interventions showed they were "PRN" (as needed) with no planned times or measurable goals. The overall goal was for the resident to be provided fourteen activities weekly. c. Review of the September 2010 activity care plan flow sheet showed that for three of four weeks the resident was not provided with the opportunity to have fourteen activities. Review further showed the effectiveness of the activity was not described except for "passive" with staff visitation. d. Review of the September 2010 care plan flow sheet for the nurse aides showed that from 9/9/10 until the end of the month, four activities were provided. These activities were one-to-one visits by the nurse aides. Review also revealed no evidence the effectiveness or level of resident participation was evaluated. Review of the October 2010 care plan flow sheet for nurse	F 248	F248 The facility will ensure that an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident is provided. This will be accomplished by: 1) The care plan for resident #18 has been changed to provide more individualized and detailed information and measurable goals that are listed that are related to the resident's problem. 2) Activity care plans for all low-functioning residents will be changed to provide more individualized and detailed information and measurable goals will be listed that are related to each individual's problem. 3) Nurse aide flow sheets addressing activity participation will no longer be utilized.	11/30/201 11/30/201 11/30/201

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F 248	Continued From page 3 individualized and meaningful activities were provided for 1 of 12 sample residents (#18). The findings were: Review of the activity assessment for resident #18 showed s/he enjoyed music, reading, movies, social events and being wheeled indoors. The following concerns were identified: a. Periodic observations from 10/11/10 through 10/13/10 showed the resident did not participate in any meaningful activities. The only observed activity was when staff sat him/her in front of the television on 10/12/10 at 7:15 AM after breakfast where the resident sat with his/her eyes closed and looked to be asleep. b. Review of the care plan for activities showed the following activities were identified as interventions: music, reading and writing, spiritual, walking-wheeling outdoors, television, conversation, and visiting. All interventions showed they were "PRN" (as needed) with no planned times or measurable goals. The overall goal was for the resident to be provided fourteen activities weekly. c. Review of the September 2010 activity care plan flow sheet showed that for three of four weeks the resident was not provided with the opportunity to have fourteen activities. Review further showed the effectiveness of the activity was not described except for "passive" with staff visitation. d. Review of the September 2010 care plan flow sheet for the nurse aides showed that from 9/9/10 until the end of the month, four activities were provided. These activities were one-to-one visits by the nurse aides. Review also revealed no evidence the effectiveness or level of resident participation was evaluated. Review of the October 2010 care plan flow sheet for nurse	F 248	F248 cont'd 4) A CNA will be hired to work in the activity department to provide more 1-1 and increased meaningful activities for all low functioning residents. 5) Activity Director to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010

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F 248	Continued From page 4 aides showed no evidence the resident was provided with any activity from the beginning of the month through 10/13/10. e. During an interview with the resident's interdisciplinary team on 10/13/10 at 11 AM, the activity director said she always made care plan interventions as "PRN" based upon what the computer software program identified as needs. She further stated this resident did not respond to activities or interactions, however, periodic observations from 10/12 through 10/13/10 revealed the resident opened his/her eyes and made facial and/or body movements when touched or spoken to. Interview with the other team members revealed they thought the resident was not provided meaningful activities intended to provide quality of life for this resident.	F 248	F281 The facility will ensure that professional standards are followed related to MD's orders. This will be accomplished by: 1a) The condition of resident #40 was treated and has been resolved.	11/30/2010
F 281 SS=D	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 staff interview and medical record review, the facility failed to ensure professional standards were followed in regard to physician's orders for 2 (#14, #40) of 12 sample residents. The findings were: 1. Review of a faxed communication to the physician dated 10/3/10 showed resident #40 had sinus congestion, a cough and a sore throat. The physician's response, dated 10/4/10, was to order Levaquin [antibiotic] 500 milligrams (mg) once per day for 10 days, along with Prednisone 20 mg for 5 days. The following concerns were noted:	F 281	b) CN responsible for error was given a written counsel on 11/8/2010. Medical director reviewed medication error on 10/28/2010. 2a) Incident report was filed regarding resident #14 with a new order from MD to continue doing PPDs annually. 3) Nurses will be in-serviced regarding procedures for clarifying and communicating MD orders.	11/30/2010 11/30/2010 11/30/2010

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F 281	Continued From page 5 a. Although the physician responded on 10/4/10, the facility did not receive the fax from the physician's office until 10/8/10. In the meantime, the facility faxed the physician on 10/6/10, stating the resident was still having sinus congestion and a cough. The physician responded that day by ordering Zithromax [antibiotic] 500 mg daily for 4 days, then 250 mg daily for 3 days. Review of the medication administration record (MAR) revealed the resident started receiving the Zithromax on 10/6/10. b. When the facility received the faxed order for the Levaquin on 10/8/10, there lacked evidence nursing staff clarified the order with the physician. Review of the MAR showed the Levaquin was first administered on 10/9/10. According to the MAR, the resident received both antibiotics on 10/9/10 through 10/12/10. c. During an interview on 10/14/10 at 10:15 AM, the south unit manager stated nursing staff should have clarified the order received 10/8/10, because the resident was already on an antibiotic. According to Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008: if an order is "questionable for any reason, the physician must be notified for clarification." 2. Review of nurse's notes for resident #14, dated 5/29/08, revealed the "resident had yearly TB test after lunch. Resident complained of itching and redness. Physician was notified." Review of a physician's order dated the same day (5/29/08): "may use Benadryl 25 mg po q 4 hours PRN x3 days, allergic reaction to TB testing, chest Xray." Review of a physician's telephone order dated a week later (6/5/08) revealed "resident sensitive to skin TB test. Do not retest." Review of nurse's note, also dated 6/5/08, revealed, "Note sensitivity	F 281	F281 (cont'd) 5) Unit coordinators to audit monthly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/30/2010

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F 281	Continued From page 6 to skin TB test. Do not retest." In addition, all subsequent monthly medical administration records (MAR) and treatment administration records (TAR) including the current (October 2010) MAR and TAR stated the same thing, i.e., "Note sensitivity to skin TB test. Do not retest". Review of TB skin testing records, however, revealed the resident was given an annual TB skin test on 6/11/09 and then again on 6/9/10. Interview with the infection control nurse on 10/12/10 at 2:48 PM, revealed "The resident was most likely not allergic to the TB antigen but rather some other component in the vaccine and therefore did not experience a reaction to the PPD." However, according to the order, the test should not have been done. The nurse stated she would contact the resident's physician and request a clarification to the MAR and to the TAR. According to Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008: If an order is "questionable for any reason, the physician must be notified for clarification."	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide appropriate and adequate perineal care during 1	F 312		

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F 312	Continued From page 7 of 3 observations of that care that involved sample resident (#18). The findings were: Review of the 1/8/10 significant change, the 4/2/10 and 7/2/10 quarterly MDS assessments for resident #18 showed the resident was incontinent of urine all of the time and was totally dependent upon staff for personal hygiene. Observation on 10/12/10 at 8:20 AM revealed the resident was incontinent of urine. CNA #1 cleansed the groin area, then used the same area of the wipe to clean the perineal area. Observation also showed the CNA did not cleanse the anterior perineal area or the buttocks which were also in contact with the urine. Interview with CNA #1 on 10/12/10 at 8:50 AM revealed she was aware of the proper technique for providing perineal care, including cleansing all areas that were in contact with the urine.	F 312	F312 1) CNA #1 resigned from her position immediately after survey.	11/30/2010
			2) Nursing staff will be In-serviced on the policy and procedure for proper perineal care.	11/30/2010
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 observation, medical record review, and resident and staff interview, the facility failed to ensure adequate supervision during transfers to prevent accidents for 1 of 6 sample residents (#18) who utilized a mechanical lift. In addition, the facility failed to complete a safety assessment	~~F 323~~	3) Infection Control to audit weekly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/30/2010

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F 323	Continued From page 8 for 2 of 2 sample residents (#40, #41) with locks on their doors. The findings were: 1. Review of the 9/23/10 care plan for resident #18 showed a mechanical lift was required for all of this resident's transfers. Review of a physical therapy recommendation, dated 1/7/10, showed the resident required the assistance of two when using a mechanical lift. The following concerns were identified: a. Observation on 10/12/10 at 8:20 AM showed resident #18 was transferred from the wheelchair to bed by CNA #1 using a Hoyer lift. Observation showed the Hoyer lift bars hit the resident on the right side of the forehead during the transfer. The resident was heard to moan when hit. Observation showed only one CNA assisted with the transfer. Interview with CNA #1 at the time of the transfer revealed she always transferred the resident with the lift by herself. b. Review of an incident report dated 12/27/09 revealed the resident had a raised area above the left eye that was purplish in color. Further review of the incident report showed the apparent cause of the injury was from the mechanical lift during a transfer. c. Review of a nursing facsimile sent to the physician on 5/5/10 showed the resident had a new lesion which was described as an ecchymotic area just lateral to the right eye approximately one inch round ("probably got it from the mech. lift we use on [him/her]"). d. Interview with the resident's treatment team on 10/13/10 at 11 AM revealed the resident definitely required two staff members to assist with the mechanical lift during transfers. They also said the CNA who performed this transfer refused to allow other staff members to assist her with resident care and that she had been told to	F 323	F323 The facility will 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 will be accomplished by: 1a) Resident #18 now requires two people for all transfers. This information was documented and communicated to all nursing staff. b) CNA #1 resigned from her position immediately after survey. c) The lift will be modified with padding for further protection of resident #18. d) Procedure will be developed for communication with OT/PT therapists regarding the use of assistance devices. e) Nursing staff will be in-serviced regarding the procedure for communication with OT/PT	11/30/2010 11/30/2010 11/30/2010 11/30/2010 11/30/2010

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F 323	Continued From page 9 ask for assistance for this resident. 2. Observation on 10/12/10 at 7 AM and throughout the survey revealed a hinge with a padlock on the door to the room of resident #40. During the survey, the door was not locked. The padlock was unlocked, and hanging on the hinge. Interview with the resident on 10/12/10 at 8:47 AM revealed he wanted the lock to prevent others from going into his room when he was away. Review of the medical record showed no evidence the facility had assessed the lock for safety, including the risks of the resident becoming locked in his/her room, and how the facility would ensure the resident's safety during an emergency. On 10/14/10 at 8:50 AM, the South unit manager stated there was no safety assessment for the lock on the door. She stated the resident and the South nurse had a key to the lock. When asked how they would ensure the resident was safe behind a locked door during a fire alarm if the nurse was not available, she replied "We'd have to wait for the nurse." 3. Observation on 10/12/10 at 11:55 AM revealed resident #41 had a hinge and padlock on the outside of his/her door, that was locked during the mid-day meal. Interview with the South unit manager on 10/14/10 at 8:50 AM revealed the lock was used during meal times to keep the resident from taking food and drinks into his/her room. The manager stated this had been the facility's practice for at least the past six months. Interview with the south unit manager on 10/14/10 at 10:05 AM revealed nursing staff and the CNAs on the unit had a key to the lock for this resident's door. The unit manager stated she was unable to find any safety assessment related to the use of the lock and the potential for the resident to	F 323	F323 cont'd therapists regarding the use of assistance devices. f) Nursing staff will be in-serviced on performing a two-person transfer and operating the lift. 2a) The keyed lock for resident #40 has been changed to a DOORKNOB combination lock. The combination has been given to resident #40 and all staff. The combination has been documented on the care plan and on MAR/TAR. b) A release has been signed by resident #40 requesting his room be secured when he is not around and acknowledging the procedure for use of the lock. 3) Resident #41 lock has been removed. 4) A safety assessment will be done on all safety devices to determine appropriateness of device to situation.	11/30/2010 11/30/2010 11/30/2010 11/30/2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 323	Continued From page 10 become locked in the room.	F 323	F323 cont'd	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure adequate monitoring and that interventions were implemented to maintain nutritional status for 1 of 5 sample residents (#55) identified as having unintentional, significant weight loss. The findings were: Review of dietary progress notes showed a note by the registered dietitian (RD) dated 6/24/10 which showed resident #55 weighed 217.3 pounds (#). The resident's ideal body weight range was calculated as 155 to 180 #. The note further indicated the resident frequently refused breakfast, but ate 100% when s/he did eat meals. Observation on 10/12/10 at 12:40 PM revealed the resident ate independently in the main dining room, and ate 100% of the lunch meal. A note by the RD on 9/16/10 showed the resident weighed 200.5 #. The RD noted the resident had	~~F 325~~	5) Procedures will be developed for the use and monitoring of locks on resident room doors. 6) Nursing staff will be in-serviced on the procedure for use of locks on resident room doors. 7) Unit coordinators to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/30/2010 11/30/2010 11/30/2010

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F 323	Continued From page 10 become locked in the room.	~~F 323~~		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure adequate monitoring and that interventions were implemented to maintain nutritional status for 1 of 5 sample residents (#55) identified as having unintentional, significant weight loss. The findings were: Review of dietary progress notes showed a note by the registered dietitian (RD) dated 6/24/10 which showed resident #55 weighed 217.3 pounds (#). The resident's ideal body weight range was calculated as 155 to 189 #. The note further indicated the resident frequently refused breakfast, but ate 100% when s/he did eat meals. Observation on 10/12/10 at 12:40 PM revealed the resident ate independently in the main dining room, and ate 100% of the lunch meal. A note by the RD on 9/16/10 showed the resident weighed 200.5 #. The RD noted the resident had	F 325	F325 **The facility will ensure that a resident – (1) maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem.** **This will be accomplished by:** **1) Resident #55 has gained weight and is now eating on the South unit so s/he can be better monitored.** **2) A procedure was developed for monitoring, documenting and reporting resident weight gain/loss.** **3) Bath aides have been in-serviced on the procedures for weight gain/loss.** **4) Nursing staff will be in-serviced on the procedures for weight gain/loss.**	11/30/201 11/30/201 11/30/201 11/30/201

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	530021	A. BUILDING _____ B. WING _____	C 10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 11 experienced a weight loss of 10.3 % in the past 180 days. The RD wrote that a trial of one supplemental nutrition shake in the afternoon would be provided, and the effect on weight would be followed. The following concerns were identified: a. The vital sign report including weights was reviewed for the period between the RD notes dated 6/24/10 and 9/16/10. The following weights showed the resident was losing weight during that time period: 7/5/10- 212 #, 7/11/10- 209.2 #, 8/4/10- 205.5 #, 8/10/10- 201.4 #, 9/6/10- 198.5 #, and 9/13/10- 200.5 #. Further medical record review showed no progress notes by the RD or the certified dietary manager (CDM) during that time, and no interventions were implemented. b. When the significant weight loss was determined and documented by the RD on 9/16/10, there lacked evidence the physician was notified of the significant weight loss. c. Upon documenting the significant weight loss on 9/16/10, the RD implemented a supplemental shake in the afternoon as the only additional intervention to help with the weight loss. During an interview on 10/14/10 at 7:55 AM, the CDM stated supplements would be documented on the dietary intake forms. Review of the dietary intake forms since 9/16/10 showed no documentation of "supplements," and only two days where "snack" was documented. There lacked evidence the facility was monitoring whether or not the resident was receiving the shake. d. Review of the following weights showed that since the 9/16/10 RD note, the resident continued to lose weight: 9/19/10- 198.2 #, 9/27/10- 198.1 #, 10/4/10- 196#, and 10/11/10 at 191.3 #. Review of the medical record showed no progress notes from the RD or the CDM during	F 325	F325 cont'd 5) Dietary manager to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/30/2010

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F 325	Continued From page 12 this time. e. On 10/13/10 at 9:25 AM, the RD was asked about the resident's weight loss. The RD stated he added a shake, would need to check to see if the resident was accepting the shakes, and what impact it had on the resident's weight. At 11:30 AM the RD stated the resident had recently lost more weight rapidly, and stated, "Something else is going on." Review of the note the RD wrote that day (10/13/10) showed the resident had a dramatic weight decline, which increased in the past week. The note also documented that although the resident typically refused some meals, the resident was recently skipping meals more frequently. f. During an interview on 10/14/10 at 7:55 AM, the CDM stated she reviewed weights on a monthly basis, and if a significant weight loss was identified she would notify the nursing staff and the RD. She stated she did not make any additional documentation related to monitoring the significant weight loss for this resident. In addition, when asked on 10/14/10 at 11:17 AM if the facility had a policy on significant weight loss, the CDM replied, "Not that I'm aware of." g. During an interview on 10/14/10 at 8:50 AM, the south unit manager stated the physician should have been notified of the weight loss, but was not. The unit manager further stated the RD would communicate with nursing regarding weight loss via a communication form. She also stated the bath aide had a communication form to use if she felt there was a concern with weights. At 10:10 AM, the south unit manager stated she was unable to locate any communication forms to nursing from the RD or the bath aide for this resident. h. During an additional interview on 10/14/10 at 11:53 AM, the RD stated he did not notify the	F 325		

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F 325	Continued From page 13 physician of the weight loss. The RD stated he was in the building weekly. The RD stated that about the middle of each month the COM would review weights, and then review the weights with him. He stated, "You caught me yesterday before we had a chance to do that." When asked about monitoring since the weight loss was identified, the RD stated there "was a lack of notes, maybe." He stated the resident had been discussed, but no documentation was made.	F 325		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

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F 441	Continued From page 14 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of policies and procedures, the facility failed to ensure staff followed the accepted standards of practice in regard to handwashing and infection control practices for 2 of 12 sample residents (#18, #40). The findings were: 1. Review of the medical record for resident #18 revealed s/he was on contact isolation precautions for MRSE (Methicillin Resistant Staphylococcus Epidermidis) in the urine. Observation on 10/12/10 at 8:20 AM showed CNA provided perineal care for the resident who had been incontinent of urine. The observation showed the CNA did not remove her gloves or wash her hands after providing the perineal care and prior to continuing to care for the resident. Observation showed the CNA touched the residents's skin, clothing, bedding, and the mechanical lift with soiled gloves used to perform incontinence care. Review of the facility's policy on perineal care dated August 2009 showed instructions to remove gloves and discard into designated container. Review of the facility policy on handwashing, dated April 2010, showed	F 441	F441 The facility will ensure that staff follows the accepted standards of practice in regard to hand washing and infection control practice. This will be accomplished by: 1a) Nursing staff will be in-serviced regarding the facility's hand washing policy. b) Nursing staff will be In-serviced regarding the facility's policy on proper perineal care and hand washing related to perineal care. c) Infection control nurse to audit for compliance and report results quarterly to the Quality Improvement Committee. 2a) The condition of resident #40 was treated and has been resolved.	11/30/2010 11/30/2010 11/30/2010 11/30/2010

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F 441	Continued From page 15 instructions to wash hands before and after assisting a resident with personal care. During this same observation, the CNA removed her gloves after completing care for resident #18, but did not wash her hands prior to caring for the resident's roommate who also required perineal care and assistance back to a recliner. Interview with the CNA on 10/12/10 at 8:50 AM revealed she was unaware of the reason resident #18 was on contact precautions but thought it was because of a urinary infection. She said she did not know why there were isolation gowns outside the resident's room and had never used one to care for the resident. Interview with the infection control coordinator on 10/13/10 at 11:30 AM revealed all CNAs were educated on contact isolation precautions and how to care for this resident. Refer to Federal citation F502 for details regarding the facility's failure to obtain a urine culture as ordered by the physician for resident #18. The failure resulted in treating an MRSE infection with an antibiotic that was not the antibiotic of choice for seven days. 2. Refer to F281 for details regarding the facility's failure to clarify an order for antibiotics for resident #40, which resulted in the resident receiving two antibiotics.	F 441	F441 cont'd 2b) CN responsible for error was given written counsel on 11/8/2010. Medical director reviewed medication error on 10/28/2010. 2a) Incident report was filed regarding resident #14 with a new order from MD to continue doing PPDs annually. c) A procedure will be developed regarding clarifying and communicating MD orders. d) Nurses will be in-serviced regarding procedures for clarifying and communicating MD orders. e) Unit coordinators to audit for compliance and report results quarterly to the Quality Improvement Committee.	11/30/2010 11/30/2010 11/30/2010 11/30/2010 11/30/2010
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	~~F 502~~		

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F 502	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review and review of the facility's laboratory agreement, the facility failed to ensure a laboratory test was performed as ordered by the physician for 1 of 12 sample residents (#18). The findings were: Review of the medical record for resident #18 showed an untimed facsimile physician's response, dated 9/3/10, with instructions for a urine culture and then to start Cipro for seven days because of a urinary tract infection. The following concerns were identified: a. Review of the 9/7/10 physicians progress notes showed the 9/3/10 order for the urine culture and sensitivity was cancelled because the Cipro was started prior to obtaining the urine culture. Interview with the resident's interdisciplinary team on 10/13/10 at 11 AM revealed the reason the urine sample was not obtained prior to the administration of the Cipro was because it was ordered on a Friday at 4 PM (9/3/10). When the facility called the laboratory to inform them of the required test, the laboratory technician said she was ready to go home and she would not work on the weekend which would have been required in order to perform the culture. The interview further revealed the facility did not have enough staff to drive the specimen to another area laboratory. Therefore, the test was delayed until ten days after the completion of the seven day treatment with Cipro. Interview with the infection control coordinator at this same time revealed when the culture was performed it showed MRSE (Methicillin Resistant Staphylococcus Epidermidis) in the urine. She further stated Cipro was the not the drug of	F 502	F502 The facility will ensure that laboratory tests are performed as ordered by the physician. This will be accomplished by: 1) Resident #18 was put on the appropriate antibiotic and the infection has resolved. 2) Nursing staff will be in-serviced regarding the appropriate steps to take for a suspected UTI. 3) The facility has changed lab providers to ensure laboratory test are performed when ordered. 4) Unit coordinators to audit for compliance and report results quarterly to the Quality Improvement Committee.	11/30/2010 11/30/2010 11/30/2010 11/30/2010

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F 502	Continued From page 17 choice to treat MRSE. She said Tetracycline was the drug of choice. The resident required the implementation of contact isolation as a result of the MRSE. b. Review of the facility's professional services contract with the laboratory showed "The Contractor will promptly and reasonably furnish laboratory ....services on an outpatient basis for Agency residents." c. Review of physician's orders showed the facsimile instructions were not transcribed as orders until 3:19 AM on 9/4/10, the day after the instructions were received.	F 502		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 535021	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	**890 US HWY 20 SOUTH BASIN, WY**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 283	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 residents 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 medical record review and staff interview, the facility failed to complete a discharge summary including a recapitulation of stay for 1 of 1 resident (#56) whose closed record required a discharge summary. The findings were: Review of a closed medical record showed resident #56 was transferred to another healthcare facility on 6/23/10. Further review showed the transfer was anticipated However, there lacked a recapitulation of stay. On 10/14/10 at 10:30 AM, the surveyor gave the record to the medical records manager and south unit manager and asked if they could locate the recapitulation of stay. At 10:35 PM, the south unit manager brought the surveyor a note from the physician However, the note was not a recapitulation of stay. She stated they were unable to locate the required recapitulation of this residents stay.

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes the findings stated above are disclosable90 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 disclosable14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents