PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	590 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 DON Director of Nursing IP Infection Preventionist MDS Minimum Data Set RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	This Plan of Correction constitutes our Allegation of Compliance.	11/26/12
F 167 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). 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	F 167	The facility will ensure the residents' physician is notified when there is a significant change in the residents' condition. This will be accomplished by: a) Resident #9 was transferred to an acute care hospital for surgical intervention where he/she remains at this time. b) All of the licensed nursing staff will be in-serviced to promptly notify the residents' physician when there is a significant change in the residents' condition. c) Director of Nursing or designee	11/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anita Cox-Mills — TITLE: Facility Manager — (X6) DATE: 10/25/12

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

Health P o C found to be acceptable on 10/26/12 by Helen Jewell.

Copy sent to SSA on 10/29/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	850 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 157	Continued From page 1 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 medical record review and staff interview, the facility failed to inform the physician of a significant change of condition for 1 of 13 sample residents (#9). The findings were: Review of the nurses' notes dated 6/13/12 and timed at 2:30 PM showed resident # 9 developed a blister on his/her right upper thigh that measured 1 centimeter (cm) by 1 cm. Further review showed the wound continued to increase in size and it was documented on 7/14/12 that the resident also developed wounds on the right thigh and gluteal area. Review of the entire record with the wound care nurse on 10/4/12 at 9:30 AM showed the physician was not notified of the wounds located on the right thigh and gluteal area until 8/9/12, 57 days later. The wound care nurse further stated the physician should have been notified when the wounds were initially found in June 2012.	F 157	to audit daily for compliance and report quarterly to the Quality Improvement (QI) Committee for review and recommendations.	11/26/12
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have	F 225	The facility will ensure that staff report allegations of abuse immediately, and that allegations of misappropriation of resident property is reported to Healthcare	11/26/12

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

PRINTED: 10/16/2012
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
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

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 225	Continued From page 2 had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures, staff interview, and review of facility abuse investigation documentation and employee	F 225	Licensing and Surveys (HLS) and other officials as required. This will be accomplished by: a) CNA #1, #6 and RN #4 will be in serviced on the facility abuse policy and immediate reporting of allegations of abuse. b) All staff will be in serviced on the facility abuse policy and immediate reporting of allegations of abuse and misappropriation of resident property, and that infractions will result in disciplinary action up to and including termination. c) The facility abuse policy and procedure and the facility abuse investigation form will be revised to include notifying HLS and other officials as required for issues pertaining to misappropriation of resident property. d) New employees will receive a copy of the facility abuse policy and procedure upon hire and will be educated by social services or designee upon hire and every six months thereafter.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	538021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 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 225	Continued From page 3 records, the facility failed to ensure allegations of abuse were reported immediately in 3 of 4 allegations reviewed. In addition, the facility failed to ensure allegations of misappropriation of resident property were reported to Healthcare Licensing and Surveys (HLS) and other officials as required. The findings were: 1. Review of the facility's policy "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations" (WRC-2, July 2010) showed "...the person(s) observing an incident of suspected resident abuse/neglect must immediately report the incident to his/her Supervisor." Review of facility documentation of abuse allegation investigations revealed the following concerns with the timeliness of reporting: a. An allegation of verbal abuse involving resident #36 and CNA #4 revealed the incident was reported to the facility by another CNA on 6/26/12. The incident occurred on 5/4/12 or 5/5/12. b. An allegation of physical abuse involving resident #23 and CNA #4 was reported to the facility on 6/26/12 by other CNAs. The incident occurred on 5/29/12. c. An allegation of physical abuse involving resident #55 and CNA #5 was reported to the facility on 6/8/12. The incidents occurred on 5/21/12 and 6/4/12. Further review of the facility's abuse investigations showed the staff (CNA #1, CNA #6, RN #4) that did not report the allegations of abuse timely were supposed to "attend the next abuse orientation." However, review of the	F 226	e) Social Services or designee to audit monthly for compliance and report results quarterly to the QI committee for review and recommendations.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	550 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 225	Continued From page 4 employee training records showed no evidence CNA #6 or RN #4 received abuse education since the dates of the abuse allegations. CNA #1 reported abuse late on 6/25/12, but did not receive abuse re-education until 8/12/12, which was after she reported another allegation of abuse late. During an interview on 10/3/12 at 4 PM, the social services director (SSD) stated he was aware that there was a problem with staff not reporting allegations of abuse in a timely manner. He stated the facility had not done an all-staff abuse re-education in response to problems of late reporting. On 10/4/12 at 9:25 AM, the administrator confirmed there was a problem with staff not reporting allegations in a timely manner. 2. During an interview on 10/3/12 at 4 PM, the SSD stated he did not report allegations of misappropriation of resident property to HLS; he stated he had never been told to. He further stated that on 10/1/12 he became aware that resident #26 reported some missing items from his/her room, but he had not reported that to HLS or other officials. On 10/4/12 at 9:25 AM, the administrator stated that if an allegation of misappropriation of resident property was "legit", based on their investigation, or if the item was valuable, then they would notify the police. She stated if they notified the police, then they would notify HLS.	F 225		11/26/12
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	830 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 226	Continued From page 5 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy and procedure review and staff interview, the facility failed to develop an abuse policy and procedures to ensure allegations of misappropriation of resident property were reported to Healthcare Licensing and Surveys (HLS) and other officials as required. The findings were: Review of the facility's policy "Resident Abuse/Neglect Including Misappropriation of Resident Property and Resident-to-Resident Altercations" (WRC-2, July 2010) showed no mention of reporting allegations of misappropriation of resident property to HLS or the police or Department of Family Services (DFS). During an interview on 10/3/12 at 4 PM, the social services director (SSD) stated he did not report allegations of misappropriation of resident property to HLS; he stated he had never been told to. He further stated that on 10/1/12 he became aware that resident #26 reported some missing items from his/her room, but he had not reported that to HLS or other officials. On 10/4/12 at 9:25 AM, the administrator stated that if an allegation of misappropriation of resident property was "legit", based on their investigation, or if the item was valuable, then they would notify the police. She stated if they notified the police, then they would notify HLS.	F 226	The facility will ensure that staff report allegations of misappropriation of resident property to HLS. This will be accomplished by: a) The facility abuse policy and procedure and the facility abuse investigation form will be revised to include notifying HLS and other officials as required for issues pertaining to misappropriation of resident property. b) All staff will be in serviced on notifying HLS and other officials as required for issues pertaining to misappropriation of resident property. c) Social Services or designee to audit monthly for compliance and report results quarterly to the QI committee for review and recommendations.	11/26/12
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	538021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	660 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 241 SS=E	Continued From page 6 INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interviews, the facility failed to allow residents significant opportunities to make food choices during meals in 3 of 4 dining areas. The findings were. Observations at lunch and evening meal times on 10/2/12 and 10/3/12 in the main dining room showed dietary staff interacted with residents. The observed interactions included personable greetings, resident-focused conversation, and actively soliciting the resident's choice of meal entree: either the planned meal selection or an alternative meal of choice. Residents appeared to respond positively to the meal setting and staff interactions at meal time. The following concerns were identified in the other three dining rooms: 1. Confidential interview on 10/3/12 at 11:25 AM with a resident revealed s/he was not provided an alternative menu at meal times in the North dining area. S/he stated only the posted menu entree was offered to him/her at meal times. 2. Random reviews of the menu boards located in 3 of the 4 dining areas did not show an alternative menu choice for residents. Review of the posted menu in the main dining room showed an	F 241	The facility will ensure residents are allowed significant opportunities to make food choices during all meals. This will be accomplished by: a) Nursing staff on North and South will inform residents of food choices during the breakfast meal for the lunch meal, during the lunch meal for the dinner meal and during the dinner meal for the breakfast meal. The cook will then be notified of these requests. If a resident requests something different at the time the meal is served, the cook will be notified and another item will be substituted. b) The menu boards will be changed to include an alternative menu choice for residents. c) Nursing and dietary staff will be in serviced on this new protocol. c) Dietary manager or designee to audit weekly for compliance and submit results quarterly through the QI process for review and recommendations.	11/26/12

PRINTED: 10/19/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	990 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 241	Continued From page 7 alternative entree; alternative food items were not offered by CNAs serving meals in the two North dining rooms or South dining area. 3. Observation in the South unit of the lunch and evening meals on 10/2/12 and the lunch meal on 10/3/12 revealed staff did not offer the residents a choice for the meal. Review of the posted menu in the dining room revealed only the main choice was written. During a confidential interview on 10/3/12 at 10 AM, a resident who ate in the South dining room stated s/he was not offered a choice for meals. S/he stated "they just send one thing, they don't ask us." On 10/3/12 at 11:55 AM, the CNA (#7) at the steam table stated staff needed to let the kitchen know one hour before meals if they needed any alternates. When asked if residents were asked what they would like to eat, she replied "there are just certain ones we ask" because some residents were more vocal about not liking the food. 4. An interview on 10/3/12 at 12 PM with CNA #3 in the North dining room revealed residents could request an alternate meal. The daily menus were posted in the dining areas at the start of each day with one main entree displayed and if the residents didn't like the main entree, they were to inform the nursing staff. The kitchen would then be notified of the resident's request. Further, the residents were not told in advance what the alternative menu choice was. Random observations of the meal service lunch and dinner during the survey showed residents were not offered an alternate meal choice. 5. The dietary manager stated in an interview on 10/3/12 at 10:40 AM that she instructed her staff	F 241		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	550 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 241	Continued From page 8 to "...always ask them [residents] what they would like to eat" and monitored the interactions to ensure dietary staff complied with her instructions. The manager further stated that she also told the CNA staff serving food in the North and South dining rooms to offer residents a choice of alternative meals if they did not like the main entree. She acknowledged there were "...not many times..." when requests for alternative food items were received from North and South residents. The manager stated alternative meals were provided more frequently in the main dining room, attributing the increased frequency to the dietary staff actively offering residents alternative choices.	F 241		11/26/12
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	F 274	The facility will ensure that a significant change Minimum Data Set (MDS) assessment is completed when a resident has a decline or improvement in two or more areas. This will be accomplished by: a) A significant change of condition assessment will be completed on resident #57. b) All resident assessments will be reviewed by the two MDS coordinators to determine whether they have had an improvement or decline in two or more areas to ensure that a significant change assessment is completed if	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

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 274	Continued From page 9 significant change MDS assessment for 1 of 3 sample residents (#57) who required that assessment. The findings were: Review of the 4/13/12 annual MDS assessment showed resident #57 required limited assistance (coded as a "2") for dressing and personal hygiene. However, review of the following quarterly assessment, dated 7/6/12, showed the resident now required extensive assistance (coded as "3") for dressing and personal hygiene. During an interview on 10/4/12 at 9:45 AM, MDS coordinators #1 and #2 stated they did not do a significant change assessment because they understood that the two changes which would trigger a significant change needed to be in different areas. They stated since the two changes were both in activities of daily living (ADLs), it did not meet the criteria for a significant change assessment. In addition, they stated their software program ran an "assessment compare," which indicated a significant change assessment was not required. On 10/4/12 at 10 AM, the MDS coordinators reviewed the RAI User's Manual with the surveyor and confirmed a significant change assessment should have been completed. According to the Long-Term Care Resident Assessment Instrument User's Manual, MDS 3.0, April 2012, by the Centers for Medicare and Medicaid Services, a significant change assessment was appropriate "...if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement)."	F 274	warranted. c) The MDS coordinators will be in serviced to not rely on the coworker program "MDS Compare" in order to decide when to set up a resident for a change of condition. Instead they are to do a change of condition in resident status "improvement or decline" per the Resident Assessment Instrument (RAI) manual guidelines. d) This will be monitored by the director of nursing or designee on a monthly basis with results reported quarterly through the QI process for review and recommendations.	11/26/12
F 314	483.25(p) TREATMENT/SVCS TO	F 314		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	699 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 314 SS=G	Continued From page 10 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policies, the facility failed to ensure 1 of 2 sample residents (#9) with pressure ulcers received the necessary treatment and services to promote healing and prevent new ulcers from developing. The physician was not notified timely and the facility failed to re-evaluate the treatment despite the worsening of the pressure ulcers, resulting in harm. The findings were: An observation on 10/2/12 at 10:35 AM showed resident #9 had open wounds on his/her right thigh and coccyx. Review of the medical record showed s/he had diagnoses to include multiple sclerosis, cancer and a history of pressure ulcers. Review of the 7/20/12 quarterly MDS assessment showed the resident required extensive assistance for bed mobility and s/he was totally dependent on staff for transfers. In addition, review of the Braden scale assessment dated 4/28/12 and 7/17/12 showed the resident was at high risk for developing pressure ulcers. Review	F 314	The facility will ensure that a resident with a pressure ulcer receives the necessary treatment and services to promote healing and prevent new ulcers from developing. This will be accomplished by: a) Resident #9 was transferred by ambulance to an acute care hospital for surgical intervention where he/she remains at this time. b) All of the licensed nursing staff will be in-serviced to promptly notify the residents' physician when a pressure sore is identified so that appropriate treatment/interventions can be implemented. c) Director of Nursing or designee will monitor daily and report results quarterly through the QI process for review and recommendations.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	680 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 314	Continued From page 11 of nursing notes showed on 8/13/12 the resident had developed a "blister" on his/her right upper thigh that measured 1 centimeter (cm) by 1 cm. The following concerns were identified: 1. Further review of the nurses' notes showed the wound became larger in size and the resident developed additional areas of skin breakdown. Review of nursing notes showed: a. On 8/24/12 at 11:06 AM the resident had developed 3 open areas in the same location. The wounds were dressed with Allevyn adhesive. b. On 7/14/12 at 3:50 PM there were three wounds to the right thigh and gluteal area. Wound #1 measured 2 cm by 1 cm, wound #2 measured 1.5 cm by 1.5 cm and wound #3 measured 5 cm by 3.5 cm. Wound #3 had "yellow brown and bloody discharge." Further review of the nurses' notes showed the wound continued to be dressed with Allevyn. c. The wound flow sheet dated 8/6/12 showed the wound located at the right gluteal fold was a stage III wound that measured 3.5 x 2 cm with yellow slough (necrotic/avascular tissue). Duoderm dressing was applied to the wound. 2. Review of the entire record with the wound care nurse on 10/4/12 at 9:30 AM showed the physician was not notified of the wounds located on the right thigh and gluteal area until 8/9/12 (57 days after onset). The wound care nurse stated the physician needed to be notified at the time the open wounds were initially found in June due to the resident's history of pressure ulcers and his/her current diagnoses. During an interview with the DON on 10/4/12 at 10:15 AM, she stated she did not know why the physician was not notified of the resident's wounds for eight weeks.	F 314		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	550 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 314	Continued From page 12 Review of the medical record showed the physician assistant (PA) assessed the wounds on 9/9/12, but no new orders were written. According to the facility's policy "Skin and Wound Management" from the Nursing Services Policy and Procedure Manual (undated), "The physician will authorize pertinent orders related to wound treatments including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, act) and application of topical agents." In addition, it stated: "The physician will help identify medical interventions related to wound management..." 3. Review of the medical record showed no evidence the treatment of the pressure ulcers was re-evaluated or altered, despite the fact that the pressure ulcers were not healing, until 9/6/12, when a fax was sent to the physician to request a physical therapy consult for wound care. During an interview with the wound care nurse on 10/4/12 at 9:30 AM, she stated the wound treatment should have been reevaluated when it was determined the wounds were not improving. Review of the Wound Initial Evaluation completed by physical therapy on 9/13/12 showed the resident had one stage III pressure ulcer on the right upper buttock that measured 4 cm by 4 cm. In addition the document showed a second wound that was unstagable that measured 8.7 cm by 8.5 cm. The wound was unstagable due to eschar (thick, leathery, frequently black or brown in color, dead or devitalized tissue).	F 314		11/26/12
F 368 88=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times	F 368		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

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 368	Continued From page 13 comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to offer all residents a snack prior to bed. The resident census was 66 at the time of survey. The findings were: During a group interview with residents on 10/2/12 at 1:30 PM it was noted by these residents that they were not all offered evening snacks. An interview with a resident who resided on the North unit on 10/3/12 at 2:15 PM confirmed evening snacks were available for residents, but staff did not routinely offer residents an evening snack. Interview with CNA #2 on 10/3/12 at 6:55 PM revealed residents were not given an evening snack unless an order was noted to provide a dietary supplement. She further stated residents could ask for a snack, but staff did not routinely	F 368	The facility will ensure that all residents are offered a snack prior to bed. This will be accomplished by: a) Licensed nursing staff and certified nurse aides will be in serviced on offering residents a snack prior to bedtime. b) This will be monitored weekly by the dietary manager or designee for compliance with results reported quarterly through the QI process for review and recommendations.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 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 368	Continued From page 14 ask residents if they wanted something to eat before bed. An observation of the North common area at that time showed snacks were located behind a closed door that was posted, "Staff members only". The dietary manager stated in interview on 10/3/12 at 2:36 PM that her staff prepared evening snacks for staff to serve residents on each unit. She acknowledged that snacks were made available for nursing staff to serve residents, but she did not know how often residents were actually offered, and accepted, a snack before bed.	F 368		11/26/12
F 425 88=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	The facility will ensure the expired medications are removed or used prior to the expiration date. This will be accomplished by: a) The task of removing expired medications will be assigned to the night shift charge nurse and added their duty log. b) Licensed nursing staff will be in serviced on this job responsibility. c) Education Specialist to monitor monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	800 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 425	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's policy and procedures, the facility failed to ensure medications were removed or used prior to the expiration date on 1 of 2 nursing units. The findings were: Observation on the North nurses station with RN #1 on 10/3/12 at 2:50 PM showed 2 vials of Epogen for non-sample resident #10 were expired on 9/12. In addition, 10 vials of Phenergan were expired with the following dates: 5 vials expired on 9/12, 4 vials expired on 2/12 and 1 vial expired on 5/12. Interview with the RN at that time revealed the medications needed to be removed when they had expired. Review of the policy and procedure for; Storage of Medications, policy #5200 dated August 2001 showed: "Outdated, contaminated, or deteriorated medications...are immediately removed from stock..."	F 425		11/26/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	The facility will ensure that medications are dated when opened and made available for use. This will be accomplished by: a) A policy and procedure regarding that medications be dated when opened and made available for use will be implemented.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	900 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 431	Continued From page 16 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's policy and procedures, the facility failed to label all medications that were opened and available for use in 1 of 2 medication storage rooms and 2 of 3 medication carts. The findings were: 1. An observation on 10/2/12 at 8:30 AM, during a medication pass with RN #2 and RN #1 for non-sample resident #2 showed his/her bottle of Visine eye drops was not labeled with the date it was opened. RN #1 acknowledged, at that time, the medication needed to be labeled with the date	F 431	b) Licensed nursing staff will be in serviced on the policy and procedure. c) Education Specialist will monitor monthly and report results quarterly through the QI process for review and recommendations.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	538021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 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 431	Continued From page 17 it was opened. 2. An observation on 10/2/12 at 9:10 AM during a medication pass with RN #2 and RN #1 showed non-sample resident #29 had a multiple dose vial of Procrit not labeled with the date it was opened. 3. Observation on 10/2/12 at 5:10 PM with RN #3 showed the blue medication cart at the North nurses' station had stock medications to include one bottle of Milk of Magnesia and one bottle of liquid guaifenesin. The bottles were not labeled with the dates they were opened. 4.Observation on 10/3/12 at 2:50 PM with RN #1 in the North medication room showed the refrigerator contained two multiple use vials of Procrit for non-sample resident #29 were not labeled with the date opened. An interview with the RN at that time revealed medications needed to be labeled with the date they were opened. 5. Review of the policy for Vials and Ampules of Injectable Medications, IIA3 dated 2008, showed; "The date opened and the initials of the first person to use the vial are recorded on multidose vials."	F 431		11/26/12
F 441 88=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	F 441		

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	680 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 441	Continued From page 19 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 by: Based on observation, staff interview, and review of infection surveillance activities and product label information, the facility failed to sustain an effective infection surveillance program and, further, failed to investigate delayed antibiotic therapy for 1 of 2 sample residents (#28) receiving antibiotics. In addition, the facility failed	F 441	The facility will ensure the infection control surveillance program is sustained, that antibiotic therapy for residents is not delayed, that staff compliance with infection control practices is systematically monitored, that in-dated hand hygiene products are in use and that chemical disinfectants are labeled. This will be accomplished by: a) A policy and procedure will be implemented where if nursing staff is unable to get a response from the primary physician after three attempts in a shift, then the on-call physician will be notified. If the desired response is not rendered, the medical director will then be contacted. b) A resident infection reporting form with a specific evaluation criteria for infections for accurate data collection to be utilized by licensed nursing staff will be implemented as a communication tool.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 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 441	Continued From page 19 to systematically monitor staff for compliance with infection control practices, maintain in-dated hand hygiene products, and properly label chemical disinfectants. The findings were: 1. Surveillance activities were reviewed on 10/2/12 beginning at 10:10 AM. These documents revealed a failure to effectively communicate requirements for antibiotic therapy and a further failure to investigate an apparent breakdown in essential staff interactions, evidenced as follows: a. Documentation showed that resident #28 was diagnosed with a urinary tract infection (UTI) on 9/8/12 based on symptoms; on this date the resident was started on an antibiotic (Bactrim DS). Physician follow-up on 9/11/12 included an order for a urine culture and, if necessary, antimicrobial sensitivity. b. A laboratory report dated 9/14/12 showed the bacteria Escherichia coli was isolated from the resident's urine sample and the isolate demonstrated resistance to trimethoprim/sulfamethoxazole [Bactrim DS]. The resistance pattern was noted by nursing staff on 9/14/12 and reported to the physician for consideration of an alternative antibiotic with efficacy against the E. coli isolate. There was no further communication among the provider staff until 9/18/12 when a telephone order was received to change the resident's antibiotic therapy to ciprofloxacin. c. Further review of surveillance records failed to show evidence the facility evaluated the 4-day (Friday 9/14/12 through Tuesday 9/18/12) delay in initiating antibiotic therapy based on laboratory findings. Interview with the IP on	F 441	c) The Education Specialist will develop a method in order to demonstrate a quantitative method for monitoring infection prevention processes among staff. d) Clean products have been removed from the soiled utility rooms and medical waste receptacles have been placed in each soiled utility room for disposal of medical waste. e) Small bottles of hand sanitizer will be purchased so staff can dispose of when empty and obtain a new bottle. f) Environmental services will implement a process to alert staff when the hand sanitizer in the wall dispensers has expired and needs replaced. g) CNA #1 will receive one-to-one education on appropriate gloving/hand washing practices. h) Licensed staff will be in serviced on the protocol for physician notification and resident infection reporting.	11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	590 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 441	Continued From page 20 10/2/12 at 11:55 AM confirmed she was aware the resident's initial antibiotic therapy was not effective and, further, revealed the resident continued to voice complaints of discomfort and painful urination from the 9/6/12 onset through 9/18/12 when ciprofloxacin treatment was initiated. The IP acknowledged the facility failed to investigate their processes for communicating antibiotic resistance with the physician staff and effecting changes in therapy in the absence of timely physician response. d. The DON stated in interview on 10/3/12 at 2:35 PM that nursing staff were instructed to contact the medical director when unable to communication with the primary physician. She stated staff were reluctant to contact the director on weekends and preferred to wait for a reply from the primary physician. The DON acknowledged the situation with resident #26 and treatment of his/her UTI demonstrated the system for alterative physician contact did not work. She further acknowledge the facility failed to initiate a causal analysis of the breakdown in communication or investigate other methods of obtaining an order for antibiotics on weekends. 2. The IP described her surveillance data collection methods in interview on 10/2/12 at 10:15 AM. She stated surveillance activities relied on information that was passively obtained from staff by passing notes or copies of laboratory reports to her in-box. The IP further stated she periodically reviewed shift reports and medical charts for infection-related information, but had not determined the validity of the passive information flow. She further stated staff did not use a standard set of criteria to evaluate potential resident infections; the IP acknowledged the lack	F 441	i) Nursing staff will be in serviced on the appropriate use of clean and soiled utility rooms. j) All staff will be in serviced on ensuring spray bottles are labeled appropriately, that boxes of gloves are not kept near a sink, the protocol for use of the individual sized and wall hung hand sanitizers, as well as appropriate gloving/hand washing infection control practices. k) The Education Specialist will monitor monthly for compliance and report results quarterly through the QI process for review and recommendations.	11/26/12

PRINTED: 10/19/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

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 441	Continued From page 21 of specific evaluation criteria might contribute to inaccurate reporting in the current system of data collection. 3. Process surveillance activities were reviewed with the IP on 10/2/12 at 11 AM. The IP stated during the review that the facility had identified several key processes for preventing infection: hand hygiene, wound care, and practices in laundry, housekeeping, and environmental cleaning. When asked about data collection and analysis in support of these indicators, the IP provided general checklists and, in the case of hand hygiene, a group competency assessment of 10 CNAs performing hand washing. The IP was unable to demonstrate a quantitative method for monitoring infection prevention processes among staff. She further stated at this time that monitoring was recently assigned to the education coordinator. Interview with the education coordinator, RN #1 on 10/2/12 at 2:40 PM confirmed she was recently assigned the task of monitoring infection prevention indicators to assess staff compliance. She acknowledged the facility lacked a systematic method of monitoring staff practices in infection control and characterized monitoring activities as "...a work in progress..." 4. Tour of the facility on 10/1/12 through 10/3/12 revealed the following discrepancies in infection control practices among facility staff: a. Random inspection of 3 soiled utility rooms showed facility staff stored clean personal care items (razors, oral hygiene products, disposable masks, paper towels, drinking cups and straws, cotton balls, toilet paper) in rooms designated for	F 441		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	850 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 441	Continued From page 22 storage of soiled linens, medical waste (red bag trash), and household trash. In addition, red bagged trash was positioned on top of household trash bins, requiring staff to repeatedly handle the medical waste bags in order to dispose of household type trash. Interview with the IP on 10/2/12 at 10:10 AM confirmed the observed practice of mixing clean and dirty items was not acceptable. She further stated red bagged trash was placed on top of other trash receptacles to ensure housekeeping removed medical waste daily; she acknowledged the practice presented an unnecessary risk for staff exposure to potentially infectious material. The DON stated in interview on 10/4/12 at 10:20 AM that she had previously instructed staff to remove personal care items from the soiled utility rooms. She acknowledged the practice of commingling clean and soiled items was not acceptable. b. Hand hygiene products were observed throughout the facility that were either post-expiration or lacked an expiration date on the label. The IP stated in interview on 10/3/12 at 12:10 PM that housekeeping staff refilled the alcohol-based hand rub (ABHR) from other containers and the expiration dates on pump dispensers was not necessarily correct. She acknowledged she did not know the correct expiration dates for some containers, did not know how often products were topped off, could not trace ABHR to a specific lot number in the event of a product recall, nor did she know if the efficacy of newer ABHR was diminished when diluted by expired product. c. Observation on 10/3/12 at 10:10 AM showed CNA #1 provided incontinence care to resident #11 with gloved hands. After the care	F 441		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	C 10/04/2012

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 441	Continued From page 23 was provided, the CNA removed her gloves, but did not wash her hands. The CNA then adjusted the resident's pillows and transported him/her into a common area. An interview with the CNA on 10/4/12 at 8:40 AM revealed she knew she needed to cleanse her hands after she removed her gloves. Review of the facility's policies and procedures for Hand Washing/Hand Hygiene, revised April 2012, showed: "...If hands are not visibly soiled, use an alcohol-based hand rub containing 60-90% ethanol or isopropanol for all the following situations: ...after removing gloves ..." d. Random observation throughout the facility showed spray bottles were commonly kept on housekeeping carts, in utility rooms, and in the laundry area. Of 14 bottles examined, 10 failed to have complete and accurate labels identifying the contents, lot numbers and expiration dates, instructions for use, or date of preparation. The IP stated in interview on 10/2/12 at 11:15 AM that housekeeping staff refilled the spray bottles with a chemical disinfectant; she acknowledged the containers were not labeled appropriately. Subsequent interview with the housekeeping supervisor on 10/4/12 at 9:40 AM confirmed that her staff refilled spray bottles with disinfectant and cleaning products; she further acknowledged the containers were not labeled appropriately. e. Observation of the soiled utility room in the closed unit on North wing on 10/2/12 at 9:20 AM showed an opened box of disposable gloves were placed beneath a paper towel dispenser adjacent to a hand washing sink. Closer inspection revealed small, circular marks on the glove box that looked like dried water drops. The	F 441		11/26/12

PRINTED: 10/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536021	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	550 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 441	Continued From page 24 IP acknowledged in interview on 10/2/12 at 9:55 AM that staff might drip or splash water into the open box of gloves when reaching for a paper towel, potentially contaminating gloves later used by staff.	F 441		11/26/12