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 03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER HEALTHCARE & REHABILITATION CENTER	1002 FOREST DRIVE RIVERTON, WY 82501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure 2 non-sample residents (#41, #69) were evaluated as safe to self-administer medications. The findings were: 1. Observation in the secure unit on 3/10/10 at 2:08 PM showed licensed practical nurse (LPN) #1 handed non-sample resident #69 a cup containing pills and another cup containing water. The LPN turned around after handing the resident the two cups, and failed to watch the resident take the pills. With her back to the resident, the LPN asked if the pills went down; the resident responded "Yes." 2. Observation at 2:10 PM revealed LPN #1 handed non-sample resident #41 a medication cup containing two white pills and a cup with water. After handing off the two cups, the LPN turned her back to the resident. The resident walked away holding the cups, s/he walked about 20 feet, took the pills with the water, and threw the cups into the garbage can. The LPN failed to watch the resident take the medication and did not ask the resident about taking the pills. 3. Interview with LPN #1 at 2:12 PM revealed this was how these two residents always took their	F 176	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F176 Self Administration of Drugs This requirement will be met as evidenced by: a. Medication self-administration evaluations will be completed for residents #69 and #41 by charge nurse. LPN #1 will be inserviced by SDC on medication administration policies, including those related to self-administration of medications. b. Medication self-administration evaluations will be completed for all residents on admission and anytime a resident expresses a desire to self-administer medications. On residents self administering medications, evaluations for continued safe self-administration will be completed by charge nurse/designee quarterly and anytime a change in ability to self administer safely is noted. SDC/Designee will inservice all licensed nurses on medication self administration policies and procedures. c. DNS/Designee will conduct random checks of medication administration for both licensed nurse administration and	4/16/10

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

Accepted 4/13/10 Telephone call w/ Cheryl pg. 32 with Bonnie Dezo NHA.

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.

4/13/10

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F 176	Continued From page 1 medications. She was not sure where the documentation was located in the residents' records; however, she thought they were safe to self-administer their medications. Interview with the director of nursing services (DNS) on 3/10/10 at 3:45 PM revealed there were no evaluations completed for these residents related to self-administration of medications. The DNS stated the residents had not expressed any desire to self-administer medications, and the nurse would need to be educated. Record review for residents #41 and #69 showed no self-administration evaluations.	F 176	***This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*** F176 Self Administration of Drugs Continued from page 1 residents self administering to assure policies and procedures are followed. Health Information Manager/Designee will conduct admission audits to assure medication self-administration evaluations are completed. Case Manager/Designee will assure self medication evaluations are complete on any current residents expressing a desire to self-administer and any residents that self administer who have experienced a change of status. d. Any concerns noted in completion and follow-through on medication self-administration evaluations will be addressed through the initiation of Performance Improvement Action teams and referral to the Performance Improvement Committee.	4/16/10
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 sample resident (#54), and 2 non-sample residents (#48, #31) were treated in a dignified manner during 3 random observations. The findings were: 1. Observation in the secure unit on 3/8/10 at 5:55 PM and on 3/9/10 at 8:30 AM revealed the table nearest to the sink was visibly soiled with dried liquids and food crumbs. In both instances, the table was not cleaned prior to residents #48 and #31 being seated and served their meals by the staff. Interview on 3/10/10 at 2:10 PM with licensed practical nurse #1 revealed the tables should have been cleaned prior to the residents	F 241	F241 Dignity and Respect This requirement will be met as evidenced by: 1 a. Tables for residents #31 and #48 will be cleaned immediately.	03/09/10

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F 241	Continued From page 2 eating. She stated "We probably got wrapped up and failed to notice." 2. Observation on 3/9/10 at 9:45 AM showed certified nurse aide (CNA) #1 pushed resident #54 to his/her room for perineal care due to urinary incontinence. Upon reaching the room, the CNA left to obtain a protective pad for the bed. The CNA said the resident was "soaked" and his/her slacks were wet. Observation confirmed that statement and also revealed the wheelchair cushion was wet. After completing perineal care, the CNA placed the clean brief and then the resident's clean clothing on top of the wet pad, contaminating them with urine. Then, without cleaning the wet cushion, the CNA assisted the resident back into a wheelchair. A previously attempted interview on 3/8/10 at 4:10 PM revealed the resident would not respond to questions. On 3/10/10 the director of nursing services stated her expectation was that the wet pad would be removed before clean, dry items were placed on the resident, and the wheelchair cushion should be cleaned before being reused.	F 241	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F241 Dignity and Respect Continued from page 2 b. Dining room tables will be cleaned by staff following use to assure a clean, dignified environment for resident dining/use. c. Housekeeping/Activities/Nursing Staff will be inserviced by Housekeeping Director on proper cleaning of resident dining tables and chairs after resident use. Housekeeping Director will complete random audits to assure an ongoing clean, dignified dining area is provided to residents. d. Any persistent or recurring noted concerns will be referred to the Performance Improvement Committee by the Housekeeping Director for further action/resolution.	
F 248 SS=E	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, medical record review, and review of the activity schedule, the facility failed to provide functional stimulation		2.a. Skin checks will be completed by a licensed nurse to assure skin integrity and cleanliness are provided to resident #54. CNA #1 will be inserviced by SDC/Designee on correct procedure for care of urinary incontinence. b. Weekly skin checks will be complete by licensed nurses on all residents to assure resident skin is clean and intact,	03/10/10 4/12/10 (Per Joan)

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F 248	Continued From page 3 or meaningful life activities for 4 sample residents (#54, #65, #11, #25), two supplemental sample residents (#44, #48), and 11 non-sample residents (#1, #3, #12, #15, #23, #27, #31, #32, #34, #36, #58) who the facility determined required one-to-one activities. The findings were: 1. Observation on 3/8/10 at 4:10 PM and 6:38 PM showed resident #54 seated in a wheelchair in his/her room with the privacy curtain pulled. The resident was sitting with his/her head bowed, eyes shut, and was facing the wall. On 3/9/10 at 2 PM observation showed staff wheeled the resident into his/her room and positioned the resident facing the wall. At that time, the resident was holding a doll, but was not interacting with it in any way. The resident sat with eyes shut and head bowed. The resident was positioned in a manner that prevented the resident from seeing into the hallway or out the window. Furthermore, the walls had been painted a shade of brownish tan so the room was dim because the lights were off, and the blinds were half shut. Observation on 3/9/10 at 8:45 AM revealed staff pushed the resident to the television area opposite the back nurses' station. The resident remained there with his/her head down and eyes shut until 9:45 AM. During that one hour time period, staff did not interact with the resident, and the resident gave no indication s/he was aware of the surroundings or that s/he was "People Watching" as was noted to be documented as on the resident's activity flow sheet. The resident was also coded on the activity flow sheet as "Active" for music, TV/radio/movies, and pet visits on this day. Observation on 3/9/10 at 10:25 AM during the "Sit to be Fit" activity showed the resident did not participate and, again, sat with his/her head		*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F241 Dignity and Respect Continued from page 3 (unless skin issues otherwise assessed and noted prior) CNA's will be inserviced by SDC/Designee on policies and procedures for provision of care following a resident episode of urinary incontinence. c. Weekly skin check results and random observations of resident incontinent care will be reviewed by the SC/Designee to assure compliance with policies and procedures related to resident incontinent care. d. Concerns related to provision of resident incontinent care will be referred to the Performance Improvement Committee by the SDC/designee for further follow-up. F248 Activities Interests/Needs This requirement will be met as evidenced by: a. Activity needs assessments and program development appropriate to meet functional stimulation needs will be completed by the Activity Director for residents #54, #65, #11, #25, #44, #48, #1, #3, #12, #15, #23, #27, #31, #32, #34, #36,	03/10/10 4/16/10

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F 248	Continued From page 4 bowed and eyes shut. Although the resident was seated next to the activity aide, during the ten minute observation, the aide made no attempt to involve the resident in the activity. 2. During random observations on 3/10/10 from 9:05 AM through 11 AM, resident #65 was asleep in a wheelchair and would not arouse when spoken to. Review of the resident's 12/1/09 quarterly Minimum Data Set (MDS) Assessment showed the resident was coded for short and long term memory problems, and was severely impaired related to decision-making. Review of the activity log for 3/10/10 showed the resident was coded as "active" for Music, TV/Radio/Movies, Pet Visits, and Relaxation, and "individual" for People Watching, during the time of this 3/10/10 observation. The resident also had one-to-one activities documented only once a week for reading newspapers or magazines. Further review showed the facility had no conducted oan activity assessment for this resident. During an interview with the activity director on 3/10/10 at 3 PM, he confirmed the resident had no activity assessment, and stated the resident was on the activity staff list for one-to-one activities. He also said staff coded the resident as "active" during group activities based on occasional hand or eye gestures and that staff knew the resident well enough to determine if those gestures reflected active involvement. 3. During an interview on 3/10/10 at 3 PM, the activity director stated "people watching" involved a resident being placed in his/her wheelchair in front of the television across from the back hall nurses' station. He also stated that one-to-one activities were only carried out for ten to fifteen	F 248	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F248 Activities Interests/Needs Continued from page 4 #58. Activity Assistant will be inserviced by the Activity Director on correct use of Active/Passive when noting resident participation in provided activity. Care plans for those residents will be updated to assure functional stimulation needs are met. b. Activity Director will complete activity needs assessments for facility residents per policies and procedures to determine appropriate functional level and participation level and placement of residents on 1:1 program as appropriate. c. Activity calendar will be revised by Activities Director based on results of Abilities Focused Activities Assessment to assure functional stimulation needs of the residents are met. Activity staff will be inserviced by Activity Director/designee to assure activities are provided in a manner that meets functional ability levels of residents. A calendar audit will be consulted monthly x 3 to determine quality of programming.	4/16/10

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F 248	Continued From page 5 minutes per week for residents who required that interaction. Additional interview with the activity director on 3/11/10 at 9:30 AM revealed the facility had a "bunch of residents" who sat with their heads bowed and their eyes shut. He confirmed the facility provided minimal activities for those residents who were dependent and/or cognitively impaired. The director identified residents #1, #3, #11, #12, #15, #23, #25, #27, #31, #32, #34, #36, #44, #48, #54, #58, and #65 as requiring one-to-one activities. Review of the March 2010 activity calendar verified a minimum number of activities suitable for functional stimulation of dependent or cognitively-impaired residents.	F 248	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F248 Activities Interests/Needs Continued from page 5 d. The Activity Director/Designee will report findings of calendar audit and 1:1 program to Performance Improvement Committee monthly x 3 for review and recommendations.	4/16/10
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observations and staff interview, the facility failed to ensure adequate housekeeping and sanitation measures for maintaining cleanliness in the laundry room, the secure care unit, various resident rooms, and the northeast exterior pathway along the outdoor patio. The findings were: Random observations from 3/8/10 at 4:30 PM through 3/10/10 at 3:48 PM revealed the following concerns: 1. Observation on 3/10/10 at 11:33 AM revealed the laundry room had two washing machines. The	F 253	F253 Housekeeping and Maintenance Services This requirement will be met as evidenced by: a. Washing machines and attached hoses/wires will be cleaned by the Maintenance Director. Exterior pathway between North and North West entrances will be raked by the Maintenance Director/Designee for removal of cigarette butts (as weather permits), light fixture over secure unit nursing station and air vents in adjoining bathroom between resident rooms #37 and #38 will be cleaned by Maintenance Director. Housekeeping staff will complete thorough cleaning on all tables and chairs in secure unit. Housekeeping staff will clean cover guards on fans in resident	4/16/10

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F 253	Continued From page 6 exteriors of both machines (tops, sides and electrical control units), along with the water and detergent hoses and the electrical wires attached to them, were encrusted in dried dirt and lint. The maintenance manager confirmed the observation and stated the last time he used a pressurized water cleaner system to clean the washing machines, one of the machine's electrical units was damaged. As a result, he stated he was "hesitant" to use the same method to again clean the washing machines. 2. Observation on 3/10/10 at 12:05 PM revealed the exterior pathway running between the north and northwest entrances was littered with cigarette butts. The pathway ran along the outdoor patio. The maintenance manager stated at the time of the observation that he was unaware of the butts being on the ground because they had been covered by snow. He stated that the cigarette butts were visible now that the snow had melted. 3. Observation on 3/10/10 at 3:48 PM revealed an accumulation of lint on the light fixture over the nurses' station in the secure unit and in the ceiling air vent in the bathroom between resident rooms #37 and #38. Interview with the maintenance manager at that time confirmed the above observations. 4. Observation in the secure unit on 3/8/10 at 4:55 PM revealed two of the four dining tables had edges that were soiled with dried on food. There were also four chairs that were soiled with food dried onto the arms. Interview with licensed practical nurse #1 on 3/10/10 at 2:10 PM revealed she didn't pay much attention to how well housekeeping cleaned the chairs and tables.	F 253	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F253 Housekeeping and Maintenance Services Continued from page 6 clean cover guards on fans in resident rooms #6, #39, #10. b. Routine cleaning schedule for washers will be initiated by Maintenance Director to assure ongoing cleanliness of machines. Exterior pathways will be routinely checked and raked (weather permitting) by Maintenance Director/Designee to provide safe and clean exterior. Light fixtures and air vents in all areas will be cleaned per routine PM Schedule by the Maintenance Director/Designee. Housekeeping staff will clean soiled chairs and tables daily and will clean resident/common area fans when noted to be visibly dusty. c. Maintenance Director/Designee will complete PM Cleaning Schedules for washing machines, vents, and lighting fixtures. Housekeeping Director/Designee will conduct random rounds to assure ongoing compliance with cleanliness of resident dining tables, chairs and cooling fans. d. If concerns noted, Performance	4/16/10

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F 253	Continued From page 7 Interview on 3/11/10 at 9:15 AM with housekeeper #1 revealed housekeepers were expected to clean the table edges and arms of the chairs after each meal. She stated not everyone did a thorough job. 5. Observation from 3/8/10 through 3/10/10 revealed the following resident rooms: #6, #39 and #10 had fans with dirty cover guards. The fan located in the conference room also had a dusty cover guard.	F 253	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F253 Housekeeping and Maintenance Services Continued from page 7 Improvement Action Teams will be formed to address concerns with results referred by Housekeeping Director to Performance Improvement Committee.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	F 280 Right to Participate in Planning Care/Revise Care Plan This requirement will be met as evidenced by: a. MDS Coordinator will assure Care plans are appropriately revised to reflect current status and needs of residents #26 and #54. b. MDS Coordinator will confirm Care Plans for all residents are reviewed and update to reflect current status and needs of residents at each resident's routine care plan meeting. Interdisciplinary Team staff contributing to care plan development will be inserviced by the MDS coordinator/designee on accuracy and revisions of care plans.	4/16/10

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F 280	Continued From page 8 by: Based on observation, medical record review, and staff interview, the facility failed to revise the care plans for 2 of 15 sample residents (#26, #54) to accurately reflect each resident's current condition. The findings were: 1. According to the care plan last updated with the 2/7/10 quarterly Minimum Data Set (MDS) assessment, resident #54 was be toileted for incontinence, receive skim milk and small portions for a weight loss program, use a seat belt in the wheelchair, be encouraged to self propel the wheelchair, and be transferred with a mechanical lift. Intermittent observations from 3/8/10 through 3/11/10 revealed none of these interventions were implemented. The care plan contained inconsistencies with regard to the itemized interventions. Several of the interventions were repeated numerous times however, only one would be changed on the care plan. For example, on 3/10/10 at 10:23 AM the dietary manager stated the resident was recently placed on regular portions and whole milk as s/he was no longer on a weight loss program. She confirmed some of the dietary interventions had not been changed. On 3/11/10 at 9:18 AM, the MDS coordinator confirmed the care plan had not been revised to reflect the resident's current condition. 2. Review of the care plan showed resident #26 was to be transferred using a walker and contact guard assistance, toileted by staff, receive set-up assistance with meals, and receive staff assistance with a colostomy bag as needed. Random observations from 3/8/10 through 3/11/10 showed the resident changed the colostomy bag and transferred and toileted	F 280	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F 280 Right to Participate in Planning Care/Revise Care Plan Continued from page 8 c. Random care plan audits will be completed by the Director of Nursing Services/Designee to assure ongoing accuracy and revision of care plans to reflect resident current status and needs. d. Identified concerns will be presented to the Performance Improvement Committee by the Director of Nursing Services/Designee for further action, if needed.	4/16/10

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F 280	Continued From page 9 him/herself independently. Meal observations on 3/8/10 at 5:55 PM and 3/9/10 at 8:19 AM showed set-up assistance was neither provided nor offered. On 3/11/10 at 9:20 AM the MDS coordinator stated the care plan for this resident should be revised.	F 280	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 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 observation, staff interview and medical record review, the facility failed to ensure professional standards were followed related to medication administration for 2 non-sample residents (#41, #69). In addition, non-qualified staff attempted to provide nursing services for 1 sample resident (#62). The findings were: 1. During observation in the secure unit on 3/10/10 at 2:08 PM and 2:12 PM, licensed practical nurse #1 failed to follow standards of practice related to medication administration for residents #41 and #69. According to Smith, Duell and Martin "Clinical Nursing Skills Basic to Advanced Skills," Seventh Edition, Prentice-Hall, Inc., 2008: when administering oral medications, the nurse should always make sure client swallows medication. Refer to Federal citation F176 for details related to the improper medication administration for residents #41 and #69. 2. During an interview on 3/10/10 at 4 PM, resident #62 stated a "kid" had attempted to	F 281	F281 Services Provided to Meet Professional Standards This requirement will be met as evidenced by: 1. Please refer to Plan of Care for F 176 2.a. Social Services Director will meet with resident #62 to assure resident that care delivery will be provided by qualified staff. b. Social Services Director/Activities Director will assure all children present in building are properly supervised. If volunteering, Activities Director will provide children information concerning allowed tasks. Social Services Director will interview interviewable residents for input related to presence and activities of children in the facility. Activities Director/Designee will inservice staff on policies and procedures related to presence/activities of children in facility. c. Activity Director/Designee will conduct random observations of children in facility to assure ongoing compliance with expectations. Social Services Director will	4/16/10

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F 281	Continued From page 10 change his/her oxygen tank a couple of weeks ago. The resident was upset that a child was allowed to do that and stated the child's parent worked at the facility. During confidential interviews, five other residents confirmed they had seen a child attempt to change resident oxygen tanks and take blood pressures. On 3/11/10 at 8:34 AM the director of nursing services stated she was unaware of this practice, but children were not allowed to change oxygen tanks or take blood pressures.	F 281	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F281 Services Provided to Meet Professional Standards Continued from page 10 conduct random observations of children in facility to assure ongoing compliance with expectations. Social Services Director will conduct random interviews with residents (interviewable) for concerns/satisfaction with presence/activities of children when present in facility. d. Social Services Director and Activities Director/Designee will refer any ongoing concerns to Performance Improvement Committee for further action, if needed.	4/16/10
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and resident interview, the facility failed to ensure pain management was provided in an effective manner for 1 supplemental sample resident (#48) and 2 of 6 sample residents (#16, #22) who were identified by the facility as having pain. By not assessing the resident in a timely manner, resident #48 experienced avoidable pain resulting in harm. In addition, the facility failed to coordinate care for 1 of 1 sample resident (#62) who was receiving hospice services. The findings were: Pain	F 309	F309 Provide Care/Services for the Highest Well Being This requirement will be met as evidenced by: 1. a. Director of Nursing Services/ Designee will complete new pain assessments for residents #48, #16, #22. Assessments will include pain indicators	4/16/10

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F 309	Continued From page 11 1. Review of the 9/23/09 pain assessment showed resident #48 had joint pain related to arthritis. The assessment also showed the resident was unable to express verbally either his/her acceptable level of pain, or the effectiveness of an as needed (PRN) pain medication, Lortab. The assessment further showed pain intervention was necessary and referred to the resident's plan of care. Review of the care plan, dated 1/29/09, showed a primary intervention for the problems of wandering and restlessness was to "Rule out pain... " However, there was no further mention of pain as a problem for this resident throughout the care plan. Review of the most current 12/17/09 pain assessment showed the resident did not have any pain. However, the resident had received pain medication according to the December 2009 medication administration record (MAR). The resident received PRN Lortab for pain eleven times from 12/2- 12/31/09. In addition, the resident received the PRN pain medication seventeen times in January 2010, and twenty times in February 2010. Review of the December 2009, and the January and February 2010 pain monitoring flow sheets showed the signs of pain included restlessness, anxiety, and agitation. The following concerns were identified regarding the provision of pain relief for this resident in a timely manner: a. Observation in the secure unit on 3/8/10 from 4:55 PM until 6:15 PM showed the resident appeared to be in pain. During the continuous observation, the resident wandered the hallway and dining/common area of the unit with quick movements, revisiting the same areas over and over, and appeared to be anxious and looking for something. At 5:03 PM the program coordinator	F 309	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F309 Provide Care/Services for the Highest Well Being Continued from page 11 Assessments will include pain indicators and indications of pain relief. Both pharmacological approaches will be identified and indications for use/effectiveness noted. Staff caring for residents #48, #16, #22 will be inserviced by the SDC/Designee on resident care and interventions as relate to pain management. b. Director of Nursing Services/Designee will inservice licensed nurses on policies and procedures related to pain assessment treatment and documentation. Licensed nursed will assure current pain assessments are completed in a timely and thorough manner for residents. Licensed nurses will provide ongoing observations and treatment of residents with pain. c. Director of Nursing Services will complete random observations of residents, review assessments and documentation to assure ongoing compliance with policies and procedures	4/16/10

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F 309	Continued From page 12 asked the resident what s/he was searching for, the resident did not respond. The coordinator then asked the resident if s/he wanted to sit down. The resident responded "Yes" to sitting but did not sit. The coordinator did not pursue any further communication with the resident. The resident continued to wander the area in an anxious manner, occasionally sitting down for a few moments. At 6:07 PM the resident sat in a chair grimacing and moving in a rocking motion. The resident appeared to be uncomfortable and did not stay seated. S/he again began moving around the area where three staff members were working to get residents seated for the evening meal. At 6:15 PM the resident again sat down in a chair. The resident put his/her head back with eyes closed and moaned. During the 1 hour and 20 minute observation, the resident was not questioned or otherwise assessed for pain. b. According to the March 2010 MAR, the resident was assessed for pain on 3/8/10 at 7 PM and determined to have a nonverbal pain level of "5" (moderate significant pain). The MAR showed Lortab 5/500 milligrams (mg) was given. However, the MAR failed to show if the medication was effective. The pain monitoring flow sheet was blank for the month of March. c. Interview with licensed practical nurse (LPN) #1 on 3/10/10 at 9:55 AM revealed she did not assess the resident related to pain on her shift the evening of 3/8/10. She stated she was not sure what pain the resident had other than having pain prior to bowel movements. The LPN stated she might need to be more aware, because she knew the resident was given Lortab most nights. d. Although the resident was administered pain medication at 7 PM on 3/8/10, the resident had been displaying what the facility had previously identified as signs of pain for this	F 309	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F309 Provide Care/Services for the Highest Well Being Continued from page 12 related to pain management. d. Any concerns related to pain management will be addressed through a Performance Improvement Action Team and Director of Nursing Services will review results with Performance Improvement Committee. 2. a. Hospice information, including orders, assessments will be placed in the chart for resident #62. Care Plan meeting with both facility and hospice staff will be held to provide care coordination for resident #62. b. Staff Development Coordinator will inservice nursing staff on responsibilities of facility and hospice staff and required documentation for coordination of care for residents placed on hospice. Director of Nursing Services/Designee will meet with hospice nursing director to clarify roles and coordination of protocols. c. Director of Nursing Services/Designee	4/16/10

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F 309	Continued From page 13 resident since 3:55 PM. The delay in assessing the resident for pain resulted in harm to the resident who could have been relieved of his/her pain up to 3 hours and 5 minutes sooner. 2. According to the 1/6/10 annual Minimum Data Set (MDS) assessment, resident #16 experienced mild daily pain of bone, hip, soft tissue, and joints. Review of the comprehensive pain assessment dated 1/6/10 showed the resident's pain score rating was documented as 7 to 8 (on a scale of 0 [no pain] to 10 [the worst pain]). Review of the care plan showed staff were to "assess the effectiveness of pain medication" and report to the physician if ineffective and "assess and document non-pharmacological interventions for pain relief: (e.g. heat, cold, massage, positioning, music,etc.)" The following concerns with this resident's pain management program were identified: a. Although the resident was identified in the 1/6/10 MDS assessment as having some difficulty making decisions in new situations only, the resident's acceptable level of pain was not ascertained. Instead, "Unable to express" had been checked. The level of pain documented on the pain score rating ("7 to 8") of the pain assessment was described as "moderate significant pain" to "frequent significant pain at rest or severe pain with movement." On 3/10/10 at 2:10 PM the resident stated s/he would like the pain level kept at "3" or below. S/he further stated his/her current program for pain control was ineffective. b. The 1/6/10 assessment failed to describe how pain affected the resident's activities of daily living and non-verbal indications of pain were not identified. During an interview on 3/10/10 from 2:10 PM through 2:25 PM, the resident stated	F 309	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F309 Provide Care/Services for the Highest Well Being Continued from page 13 will conduct review of newly admitted residents to hospice to determine that documentation and coordination are in place. Director of Nursing/Designee will complete random audits of hospice-designated residents' charts for ongoing compliance. d. Concerns presented by the Director of Nursing Services/Designee will be reviewed through the Performance Improvement Committee for further actions if indicated.	4/16/10

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F 309	Continued From page 14 s/he "doesn't want to do anything." The resident specifically stated s/he did not want to go to the dining room because it hurt to walk. The resident further stated s/he had no interest in activities as participating caused increased pain. During the interview, the resident continually rubbed both knees which were covered with old surgical scars. The resident also had a surgical scar on the left hip. c. Even though the resident's pain rating was documented as "7 to 8," further review of the pain assessment showed the conclusion was "No pain, intervention is not necessary." An additional note documented the resident had a "long history of narcotic use...will on occasion overstate pain...will request PRN [as needed] pain med" and then be seen dancing in his/her room. There was no determination if dancing was used as a non-pharmacological intervention for pain management. d. Review of the daily pain scores showed they were documented at 8 AM and between 7 PM and 8 PM. The effectiveness of routine pain medications was not re-evaluated throughout the day. When asked on 3/10/10 at 3:50 PM how pain was evaluated throughout his shift, registered nurse (RN) #1 shrugged, but did not reply. At 2:25 PM that day the resident rated his/her pain level as a "6 to 7," which was described on the facility's pain scale as moderate significant pain. 3. Review of an undated pain assessment in the medical record for resident #22 showed the resident had left hip pain due to surgery that involved a left hip fracture. Review of a physician's order showed the resident had a 2/11/10 order for Darvocet N-100 mg for pain. Review of the care plan showed staff was required to evaluate the resident's pain after pain	F 309		

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F 309	Continued From page 15 medication administration and notify the physician for unrelieved pain. The following concerns with assessment of pain were identified: a. The resident's pain assessment was blank for the resident's description of pain, non-verbal pain information, pain effect on quality of life, causes of pain, indicators of pain relief including acceptable pain level, or conclusion as to staff interventions. The care plan required staff to notify the physician when the resident's pain was unrelieved. However, staff failed to document the resident's acceptable pain level on the care plan, and there was no documentation in the record to show the physician was ever notified of unrelieved pain. b. Review of the February and March 2010 MAR showed the resident received Darvocet N-100 mg once or twice each day. The review showed staff documented pain at "5" before and "1 to 3" on the MAR or pain monitoring flowsheets after the resident received pain medication. However, on 2/19/10, 2/27/10, 3/4/10, 3/5/10, 3/6/10, 3/7/10, and 3/8/10 staff did not document a level after the resident was medicated for pain. c. The director of nursing services was interviewed on 3/10/10 at 11:15 AM. She stated the resident's pain assessment was incomplete, and staff failed to document an acceptable level of pain on the assessment or care plan. She also stated her expectation was for staff to evaluate the resident's pain level before and after the administration of pain medication and to follow the care plan. Hospice According to the physician's orders, resident #62	F 309		

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F 309	Continued From page 16 was admitted to hospice on 3/4/10. Medical record review on 3/10/10 at 3 PM showed no evidence of coordination of care between the two facilities. The hospice assessments and care plan were lacking; thus, there was no way to determine which facility would provide specific care and services to meet the needs of the resident. Additionally, there was no indication as to which facility had overall professional management responsibility related to the terminal illness and related conditions. On 3/10/10 at 5:05 PM social workers #1 and #2 confirmed coordination of care was lacking.	F 309	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to provide care in a manner to prevent urinary tract infections for 1 of 1 sample resident (#37) with a urinary catheter. The findings were: Observation on 3/9/10 at 9:10 AM showed resident #37 was transferred to bed by certified nurse aides (CNAs) #5 and #6 with the use of a	F 315	F315 No Catheter , Prevent UTI, Restore Bladder This requirement will be met as evidenced by: a. Staff Development Coordinator will inservice CNA's #5 and #6 on proper transfer of resident #37 for correct placement of catheter bag during lift transfer. b. Staff Development Coordinator/Designee will inservice nursing staff on correct transfers of residents with indwelling catheters. c. Staff Development Coordinator/Designee will conduct random reviews of transfers of residents with indwelling catheters to assure adherence to correct policy and procedures. d. Identified needs/concerns will be	4/16/10

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F 315	Continued From page 17 mechanical lift. The resident had a urinary catheter with tubing attached to a catheter bag. CNA #5 secured the urinary catheter bag to the lift above the level of the resident's head. The bag remained above the resident's head throughout the transfer process. Yellowish-clear urine was in the catheter tubing, and some urine was observed to drain back into the resident via the catheter. CNA #5 was interviewed immediately after the transfer. She stated the catheter bag and tubing were to be kept below the level of the resident's bladder. She stated she sometimes forgets. According to the policy and procedure entitled, "Indwelling Urinary Catheter Care," #14, "To reduce the incidence of reverse flow... secure the urinary bag to hang below the resident's bladder...."	F 315	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F315 No Catheter , Prevent UTI, Restore Bladder Continued from page 17 presented to the Performance Improvement Committee by the Staff Development Coordinator/designee for further corrective action needs if indicated.	
F 323 SS=E	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, staff interview, product labeling, and reference review, the facility failed to ensure a safe environment for residents in 1 of 3 dining rooms, 1 of 3 bathing rooms and 1 of 4 hallways. The findings were:	F 323	F323 Free of Accident Hazards/Supervision/Devices This requirement will be met as evidenced by: a. Storage cupboard over music system in main dining room will be locked unless in immediate use. Missing ceramic tile on half wall will be replaced. Picture outside Room #5 with noted cracked cover will be removed and cover replaced. Flooring opposite Room 35 will be repaired to eliminate potential of tripping hazard. b. Maintenance Director will inservice staff on procedure for reporting needed repairs and observations of potential hazards.	4/16/10

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F 323	Continued From page 18 1. Observation on 3/8/10 at 4:28 PM, on 3/9/10 at 1:45 PM and then again on 3/10/10 at 11:40 AM revealed three bottles (two 32 oz. bottles and one 1-liter bottle) of Windex in an unlocked cupboard directly over the music system in the main dining room. Review of the labels showed all three bottles contained ammonium chloride. According to the Columbia Encyclopedia 6th edition, 2006, ammonium chloride is harmful if swallowed and causes skin and eye irritation. Interview with the maintenance manager on 3/10/10 at 11:40 AM revealed the cupboard doors should be locked. 2. Observation on 3/8/10 at 4:28 PM, on 3/9/10 at 1:45 PM and then again on 3/10/10 at 11:40 AM during a facility tour revealed the following additional concerns: a. A two-inch square piece of ceramic tile was missing on the half wall in one of three bathing rooms. The missing tile was about 2 - 3 feet above the floor's surface and created a potential hazard for residents and staff if they were to bump up against the wall. b. A 2 ft. x 3 ft. picture was hanging on the wall in the main corridor opposite room #5. The picture was covered in hard but flexible plastic. An approximate 5" crack was noted. The crack was approximately 5 ft. from the floor and had a sharp edge creating a hazard to anyone rubbing their fingers across the crack. c. Half of a floor tile that would be about 1 ft square was missing. The section of flooring was located opposite room #35, creating a possible trip hazard to anyone using a walker for ambulation. Interview with the maintenance manager on 3/10/10 during the tour confirmed the above observations.	F 323	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F323 Free of Accident Hazards/Supervision/Devices Continued from page 18 c. Maintenance Director/Designee will conduct routine PM rounds to determine compliance with provision of a safe, hazard free environment. d. Maintenance Director will present unresolved concerns to the Performance Improvement Safety Committee for further action.	4/16/10

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medication regimens for 2 of 15 sample residents (#26, #47) were free of unnecessary medications. The findings were: 1. Medical record review showed resident #26 was admitted on 11/16/07 with diagnoses that included depression and dementia. According to	F 329	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F329 Drug Regimen Free of Unnecessary Drugs This requirement will be met as evidenced by: a. Psychotropic medication usage with associated diagnosis for residents #26, #47 will be clarified through the Psychotropic Committee. Physicians will be asked to complete a risk versus benefits statement for each of the noted residents. b. Social Services Director/Designee will complete inservicing for licensed nursing staff on policies and procedures related to appropriate use of psychotropic medications. c. Members of the Psychotropic Committee will complete ongoing routine reviews of residents receiving psychotropic medications; providing needed interventions as indicated. d. Concerns related to psychotropic medication usage will be presented to the Performance Improvement Committee by the Psychotropic Committee Chairperson for any indicated follow-up.	4/16/10

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F 329	Continued From page 20 the physician's orders and the medication administration records (MARs), the resident had been receiving the antidepressant Celexa 20 milligrams (mg) since 1/26/08. The pharmacist requested a dose reduction of Celexa on 1/5/10. The physician's response was, "Do not attempt to taper the dose of this drug because in my professional opinion to do so is clinically contraindicated. This patient's behaviors are due to the psychiatric diagnosis, and the prescribed medication at the current dose is the appropriate treatment." There was no evidence the resident failed a previously attempted dose reduction, and the January 2010 Cornell test for depression showed the resident was not depressed. On 3/10/10 at 5 PM the director of nursing services (DNS) confirmed the resident did not have a psychiatric diagnoses and that an analysis of the risks versus the benefits of continuing the medication at the same dose was lacking. 2. According to the medical record, resident #47 was admitted on 8/7/05 with diagnoses including dementia and depression. Review of the physician's orders and the MARs showed the resident had received Klonopin 0.5 mg daily for anxiety and vertigo since 3/13/09. Review of a request from the pharmacist for a dose reduction revealed it was dated 1/5/10. However, the physician had responded, "Do not attempt to taper the dose of this drug because in my professional opinion to do so is clinically contraindicated. This patient's behaviors are due to the psychiatric diagnosis, and the prescribed medication at the current dose is the appropriate treatment." On 3/10/10 at 5:20 PM the DNS confirmed the resident did not have a psychiatric diagnosis and that a statement from the physician identifying the risks versus the benefits of	F 329		

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F 329	Continued From page 21 continuing the medication at the same dose was lacking. Furthermore, there was no evidence the resident failed a previously attempted dose reduction.	F 329	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	F356 Posted Nursing Staff Information This requirement will be met as evidenced by: a. Correct nursing staff posting has been done. b. Information will be posted on a daily basis by the Staffing Coordinator/Designee utilizing required form. c. Director of Nursing Services will conduct random reviews to assure nursing staff information is posted per requirements. d. Results of compliance review will be presented to the Performance Improvement Committee by the Director of Nursing.	4/16/10

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F 356	Continued From page 22 by: Based on observation, staff interview, and review of the staffing book, the facility failed to post its staffing data as required. The findings were: Observation from 3/8/10 through 3/10/10 showed the facility's staffing data was posted on a dry erase board at both the front and back nurses' stations. The data failed to include the name of the facility, the census, the number of hours each person worked, and the total number of hours worked per category of licensed and unlicensed staff. Interview with the director of nursing services on 3/10/10 at 10 AM revealed the dry erase board was the only thing currently being used for posting the staffing data. Review of the staffing book (which was not posted for public review) showed the facility retained 18 months of information; however, that information was also incorrect and did not meet the regulatory requirements.	F 356	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff practiced acceptable	F 371	F371 Food Procedure, Store/Prepare/Serve-Sanitary This requirement will be met as evidenced by: a. Outdate food items will be removed from walk-in refrigerator and discarded. Meat slicer tray, stand mixer and convection oven will be thoroughly cleaned. Damaged cutting boards will be discarded and replaced by new ones. Damaged ceiling area will be repaired. Utensils will be cleaned and re-hung after ceiling repair is completed. Staff Development Coordinator/Designee will inservice cook #31 on hand washing and glove us in kitchen.	4/16/10

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F 371	Continued From page 23 hand hygiene, discarded outdated food, and that food equipment was in good condition and stored in a clean manner. The findings were: a. Observation during the initial kitchen tour on 3/8/10 at 4:10 PM revealed four containers in the walk-in refrigerator that were labeled with expired use by dates. The products were: Swiss broccoli use by (3/7/10), cranberry sauce (use by 3/5/10), chicken noodle (use by 3/7/10) and lunch meat (use by 3/7/10). Observation the next morning 3/9/10 at 7:15 AM revealed these four items were still available for use in the walk-in refrigerator. The dietary manager was interviewed on 3/9/10 at 11 AM. She revealed that, according to dietary policy, the items should have been used or discarded on the dates indicated on the labels. b. Observation during the initial kitchen tour on 3/8/10 at 4:10 PM showed the meat slicer was stored on the counter and draped in a plastic cover. Inspection under the cover showed the tray of the slicer was soiled with a significant amount of off-white granules. Observation the next morning on 3/9/10 at 7:15 AM revealed the granules were still on the tray. Interview with the dietary manager on 3/9/10 at 11 AM revealed the granules were bread crumbs. She was uncertain how they got onto the tray. In addition, observation of a stand mixer located in the preparation area of the kitchen showed there was dried food splattered on the arm that held the bowl of the mixer. Finally, there was a thick black burned spill on the floor of the convection oven. Interview with the dietary manager that day at 11 AM confirmed the equipment needed to be cleaned. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean	F 371	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F371 Food Procedure, Store/Prepare/Serve-Sanitary Continued from page 23 b. Staff Development Coordinator/Designee will inservice dietary staff on food storage time limits, cleaning of equipment and handwashing and glove use. c. Dietary Service Manager will post cleaning schedule for kitchen and areas and equipment. Will monitor routinely for ongoing compliance. d. Dietary Service Manager will present related concerns to Performance Improvement Committee for additional review if indicated.	4/16/10

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F 371	Continued From page 24 to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." c. Observation on 3/9/10 at 7:15 AM showed a cutting board stand on a shelf under a preparation counter. Six of the cutting boards were deeply scored and discolored. Interview with the dietary manager later that day at 11 AM revealed the cutting boards were about 5 years old and new ones were needed. According to Food Code 2009, U.S. Public Health Service: 4-202.11..."(A) Multi-use food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections;" d. Observation in the preparation area of the kitchen on 3/9/10 at 7:40 AM showed there was leak. Six of the serving and mixing spoons that were on a holder near the hole were splattered with dried white spots. Interview with cook #1 on 3/9/10 at that time stated the leak started the weekend prior, and maintenance repaired the problem; however, the hole still needed to be patched up. Interview with the dietary manager on 3/9/10 at 11 AM confirmed what the cook said, however, didn't realize the spoons had been soiled. According to Food Code 2009, U.S. Public Health Service: 4-903.11 "(A) Except as specified in ¶ (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination;"	F 371		

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F 371	Continued From page 25 Handwashing concerns: During the observation of the morning meal service on 3/9/10 from 7:15 AM to 8:15 AM cook #1 failed to use appropriate hand washing techniques on two separate occasions. At 7:40 AM the cook stepped away from the serving line to enter the walk-in refrigerator. The cook was wearing disposable gloves at that time and failed to remove them and wash his hands after handling the door, and before returning to the line and continuing to prepare resident meals. At 8 AM the cook touched both the main door handle to the walk-in, and the side door to the walk-in which was visibly soiled with dried on food. Without changing his gloves and washing his hands, the cook returned to serving resident meals. Interview with the dietary manager on 3/9/10 at 11 AM revealed the staff had all been educated on glove use and handwashing in January 2010, and the cook should have washed his hands. According to Food Code 2009, U.S. Public Health Service,3-304.15 Gloves, Use Limitation. "(A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation."	F 371	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431	F431 Drug Records. Label/ Store Drugs and Biologicals This requirement will be met as evidenced by: a. Open and undated vials noted during survey will be discarded.	4/16/10

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F 431	Continued From page 26 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications available for use in 1 of 3 medication carts were not expired. The findings were: During an observation of the medication cart at the front nurses' station on 3/10/10 at 3:10 PM, three vials of Novolin R insulin, one vial of Novolin N insulin, and one vial of Lovenox (an	F 431	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F431 Drug Records. Label/ Store Drugs and Biologicals Continued from page 26 b. Charge nurses will check for any open and undated vials and discard them. c. Director of Nursing Services/Designee will inservice licensed nurses on policies and procedures for storage and labeling of rugs and biologicals. Random weekly observations of the medication carts will be performed by the Director of Nursing Services/Designee and corrective action taken as needed if unlabeled/undated items are unidentified. d. Findings will be reported by Director of Nursing Services to Performance Improvement Committee for review and recommendations.	4/16/10

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F 431	Continued From page 27 anticoagulant) were opened, but had not been dated, and were available for use. Registered nurse #1 was interviewed immediately after the observation and stated he could not find an open date for any of the five opened vials. He also stated he could not determine how long the vials had been opened or if they were outdated. He confirmed the vials were available for use. According to Smith, Duell, & Martin, "Clinical Nursing Skills Basic to Advanced Skills," Seventh Edition, Prentice-Hall, Inc., 2008, page 605: "If multi-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials."	F 431	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 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	F 441	F441 Infection Control. Prevent Spread, Linens This requirement will be met as evidenced by: 1. Please refer to POC F507 2. a. LPN #2 will be inserviced on policies and procedures to utilize Gluco-Chlor pads to clean glucometers. b. Director of Nursing Services/Designee will assure Gluco-Chlor pads are available at each station for cleaning glucometers. Any other pads used for cleaning of glucometers will be removed from nursing stations. Director of Nursing Services/Designee will inservice licensed staff on policies and procedures for use of Gluco-Chlor pads for cleaning of glucometers.	4/16/10

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F 441	Continued From page 28 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, medical record review, review of faxed laboratory (lab) results, and review of the manufacturer's instructions, policies and procedures, and the Material Safety Data Sheet (MSDS), the facility failed to maintain an effective infection control program. This failure affected tracking of lab results for 2 of 15 sample residents (#16, #47) and 14 other non-sample residents. One of 2 glucometers (machine for obtaining finger stick blood sugar results) was not cleaned per the manufacturer's instructions; nor were the controls for that glucometer maintained within their expiration date after being opened. The findings were: 1. During an interview on 3/11/10 at 10:30 AM, the infection control practitioner (ICP) stated culture and sensitivity (C&S) results were not always returned to the facility in a timely manner.	F 441	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F441 Infection Control. Prevent Spread, Linens Continued from page 28 c. Director of Nursing Services/Designee will complete random checks of glucometer cleaning to assure compliance with use of appropriate cleaning agent. d. Results of checks will be presented to Performance Improvement Committee by Director of Nursing Services for further actions if indicated.	4/16/10

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F 441	Continued From page 29 Review of the C&S results for resident #47, completed on 3/8/10 and faxed to the facility per request on 3/11/10, showed the infecting organism, Proteus mirabilis, was resistant to Cipro. The physician had not ordered an antibiotic to which Proteus mirabilis was sensitive by 3/11/10, and the ICP was unaware the organism was resistant to Cipro. Refer to F507 for further information related to residents #16 and #47. Without the C&S results, the ICP was unable to efficiently track and trend the types of infections occurring in the facility and or implement specific, effective measures to prevent or mitigate the spread of infections. Review of the infection control log for January, February, and March 2010 showed 16 of 29 instances (55%) where a C&S was ordered but the results were not indicated on the log. The ICP stated that although the facility did not receive the results, physicians were able to access the laboratory computer system. This resulted in the facility's inability to ensure effective clinical management of infections for its residents.. 2. During an observation at the front nurses' station on 3/9/10 at 4:20 PM, registered nurse (RN) #1 performed blood sugar monitoring for four residents using a Life Scan glucometer. Before use, after each use, and after completion of all testing, the RN used a Gluco-Chlor pad to wipe the glucometer machine and waited several minutes between cleaning before additional testing was performed. At that time, the RN stated he always used the Gluco-Chlor pads to clean the glucometer. Comparison of that observation with one at the back nursing station on 3/8/10 at 4:36 PM showed licensed practical nurse (LPN) #2 cleaned a Life Scan glucometer with a "Super Sani-cloth" wipe prior to using it on	F 441		

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F 441	Continued From page 30 another resident. After use, he again cleaned the glucometer with the same type of wipe. Review of the facility's policy and procedure entitled, "Blood Sugar Monitoring" under Procedure, #23, showed "Clean the glucometer using a 10% bleach solution moistened wipe between each resident. Allow a 2-minute contact time and wipe any residual bleach solution off of the meter." This policy and procedure reflects the manufacturer's instructions for cleaning the glucometers. According to the Material Safety Data Sheet (MSDS) for Super-Sani Cloth wipes, the ingredients include " 0-60% isopropanol, 0.25% Benzyl-C 12-18-alkyldimethyl ammonium chlorides, 0.25% Quaternary ammonium compounds, C 12-18 alkyl [(ethylphyl) methyl] dimethyl, chlorides." The remaining ingredients are inert. The total chloride (bleach) ingredients amounted to 0.5%. On 3/11/10 at 11 AM, the director of nursing services stated that all nurses should clean the Life Scan glucometer with Gluco-Chlor pad before, between, and after each use. 3. Observation at the back nurses' station on 3/8/10 at 4:45 PM showed both high and low controls for the Life Scan glucometer had been opened, but neither the date they were opened nor the expiration date was indicated on either bottle. Review of the labels showed the controls should be discarded 90 days after being opened. During the observation, LPN #2 confirmed the controls had been used. He confirmed the bottles were undated and stated he could not assure the 90 day expiration date after opening had not been exceeded.	F 441		
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

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	535031	A. BUILDING _____ B. WING _____	C 03/11/2010

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F 463	Continued From page 31 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the resident call system in optimal working condition. The findings were: Multiple observations, from 3/8/10 through 3/10/10 at various times, revealed a call bell sound was not heard upon activation of the call light system at both the front and back nurses' stations. Interview with the administrator on 3/10/10 at 4:48 PM revealed the resident call system used to have a working sound component as part of the system, but it no longer worked because of the on going overhead ventilation system construction project that "probably cut a wire." In addition, five small light bulb covers with corresponding identifying resident room numbers stamped on them were missing on the wall mounted resident call light display unit at the back nurses' station. The exposed light bulbs underneath the missing covers were all operational, but without the cover, they were subject to breakage. Also, new staff would not necessarily know which room to respond to in the event one of the unlabeled resident room call lights was turned on. Resident rooms affected were: 8, 9, 11, 37, and 39. Finally, on the wall-mounted call light display unit, five communal room locations (non resident rooms) had missing light covers. A room location	F 463	*This Plan of Correction is the Center's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F463 Resident Call System-Rooms/Toilet/Bath This requirement will be met as evidenced by: a. Needed visual and audible portions of call system for back station will be ordered. b. Call locations will be checked by Maintenance Director to assure call lights and locations are correctly identified and functioning. c. Maintenance Director will perform routine checks of call light system(s) to assure residents/staff have functioning call system in place. d. Maintenance Director will report any identified concerns to the Performance Improvement Safety Committee for review and recommendations.	4/16/10

SR 4/12/10

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F 463	Continued From page 32 was written on the call board in faded ink next to the light bulb. However, several of these notations were incorrect. For example, "phone" was written on the call board next to a light that corresponded to the social services' office and "smoke room" corresponded to the activities office. Interview with the administrator on 3/10/10 at 4:48 PM revealed not all of the penciled in markings corresponded to the correct room call light.	F 463	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the walls and floors in the kitchen were maintained in a sanitary manner. The findings were: During the kitchen observations on 3/8/10 at 4:10 PM and 3/9/10 at 7:15 AM, the walls around the preparation area were noted to have multiple areas of marring where the paint was worn off, and the walls were dirty with dried on food splatters. In addition, the floors in the preparation area, and around the convection oven were noted to have a build up of food debris under the shelving. Interview with the dietary manager on 3/9/10 at 11 AM revealed the floors should be swept each evening including under the shelves. Regarding the walls in the food preparation area, she stated it had been a couple of years since they had been painted.	F 465	F465 Safe/Functional/Sanitary/Comfortable Environment This requirement will be met as evidenced by: a. The walls around the preparation area will be cleaned and painted. The floors in the preparation area and around the convection oven will be thoroughly cleaned. b. Observation of the kitchen will be conducted to identify other areas of needed cleaning and painting and action taken to correct. c. A cleaning schedule will be established and staff will be trained. Dietary Services Manager will post cleaning schedules for kitchen areas and equipment. The dietary services Manager will monitor routinely for ongoing compliance. d. Dietary Service Manager will present related concerns to Performance Improvement Committee for additional review if needed.	4/16/10

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F 496 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to ensure 3 of 3 sample certified nurse aides (CNA) (#2, #3, #4), whose records were reviewed were safe,	F 496	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F496 Nurse Aide Registry Verification This requirement will be met as evidenced by: a. CNA certification was verified for CNA's #2, #3, #4. The Wyoming State CNA Registry was checked for CNA's #2, #3, #4. Completed 3/30/10 b. Employee files will be reviewed to determine verification of CNA certification and the State of CNA registry and action will be taken to confirm proper documentation is in place. c. The Staff Development Coordinator will be trained on necessary verification by the Executive Director/Designee. A tool will be utilized to track verifications upon hire an certification renewal. d. Random audits of CNA files will be done by the Staff Development Coordinator/Designee on a monthly basis and findings will be reported to the Performance Improvement Committee for review and recommendations.	4/16/10

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F 496	Continued From page 34 competent employees. The findings were: Review of the personnel records for CNAs #2, #3, and #4 showed the facility failed to verify CNA certification for any of the sample CNAs. Further review showed the facility failed to check the Wyoming State CNA Registry also prior to hiring these individuals as required. During an interview with the staff development coordinator on 3/10/10 at 4:45 PM, she stated the facility had failed to confirm CNA certification, and did not check the Wyoming State CNA Registry for the sample CNAs.	F 496	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.*	
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and faxed laboratory (lab) results, the facility failed to assure lab results were maintained in the medical records for 2 of 15 sample residents (#16, #47). 1. Medical record review for resident #16 showed on 3/2/10 the physician ordered lab tests that included blood cultures. Further review showed the results were not filed in the medical record by 3/10/10. Interview with registered nurse (RN) #1, on 3/10/10 at 11:35 AM revealed he did not know if the cultures had been obtained. He confirmed the results were not waiting for the physician's review before being filed. At 1:50 PM that day, the	F 507	F507 Lab Reports in Record – Lab name/address This requirement will be met as evidenced by: a. C & S results for residents #16 an #47 were obtained from the lab and placed in the Medical Record. b. The Infection Control Log will be reviewed to determine missing C & S results and charts will be audited to determine the presence of those results. The lab will be notified for missing items that will be placed in medical record. c. The Infection Control Practitioner (ICP) will be retrained on the use of the infection control log audit completion. The log will be utilized appropriately to confirm that the C & S results are received and adequately addressed. The Infection Control Log will be reviewed weekly for	4/16/10

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F 507	Continued From page 35 RN produced the faxed lab results and reiterated that they were not available from the lab prior to being faxed to the facility. 2. Review of lab results dated 3/6/10 showed resident #47 had a urinary tract infection (UTI) and culture and sensitivity (C&S) tests were needed. Further review of the medical record revealed the C&S results were not present as of 3/10/10 at 5:10 PM. Review of the physicians' orders showed the resident was started on the antibiotic, Cipro, on 3/6/10, but it was discontinued on 3/9/10. On 3/11/10 at 8:45 AM, the infection control practitioner confirmed the C&S results were missing. Review of the C&S results, completed on 3/8/10 and faxed to the facility per request on 3/11/10, showed the infecting organism, Proteus mirabilis, was resistant to Cipro. The physician had not ordered an antibiotic to which Proteus mirabilis was sensitive as of 3/11/10. Without the C&S results, the ICP was unaware the organism was resistant to Cipro.	F 507	*This Plan of Correction is the Center's credible allegation of compliance.* *Preparation and/or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.* F507 Lab Reports in Record – Lab name/address Continued from page 35 Control Log will be reviewed weekly for completion and corrective action team. d. Results of weekly review will be reported to the Performance Improvement Committee by the Infection Control Practitioner for recommendations.	4/16/10