POC accepted 10/29/10

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

PRINTED: 09/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON- Director of Nursing RN - Registered Nurse CNA- Certified Nurse Aide MDS- Minimum Data Set MAR- Medication administration record	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	The facility will ensure the accuracy, completeness, and prominent posting of all required information as evidenced by: A. Information for the State Survey Agent will be corrected to reflect the current title and correct address. The facility will add a specific statement that an individual may file a complaint with the State Survey Agency concerning resident abuse, neglect, misappropriation of property and non-compliance with advance directive requirements. B. The facility will post contact information for the Medicaid fraud unit. C. The facility will post contact information for the protection and advocacy network.	10/17/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie J McL — TITLE: Administrator — (X6) DATE: 9/24/10

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

Changes made per Deb McLean, Director of Finance on 10/29/10 @ 3pm per phone call. Janelle Cox 10/29/10

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156	D. The facility will post the correct contact information for the Regional Ombudsman on all signage. E. The facility will use a large print font (24 pt. Roman) for all required information. The Administrator will monitor the accuracy and completeness of all required posted information on a monthly basis and report at the quarterly QAA meeting with appropriate follow up.	

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation on 4 of 4 days, the facility failed to ensure the accuracy and completeness of all required information was prominently posted. Findings were: Observation of the bulletin board near the facility entrance on 8/30/10 at 8 PM and on all subsequent days of the survey revealed the following concerns with the required posted information: a. The information for the state survey agency was inaccurate. The individual listed as	F 156		

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F 156	Continued From page 3 manager was incorrect. The title of the State Survey Agent was incorrect. The address for the State Survey Agency (SSA) was incorrect. There was no specific statement that an individual could file a complaint with the SSA concerning resident abuse neglect and misappropriation of property and non-compliance with the advance directive requirements. b. There was no contact information posted for the Medicaid fraud control unit. c. There was no contact information posted for the protection and advocacy network. d. The information on the signage was incorrect regarding the long-term care Ombudsman; however, there was a separate posting that the regional Ombudsman had provided that did contain correct information. e. The font size for the posted information was 12 pt, Roman and was, therefore, not large enough to be read by an individual who required large print.	F 166		
F 167 SS=E	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation on 4 of 4 days, as well as	F 167	The facility will ensure the results of the most recent survey and plan of correction are available for examination. Results will be posted in a place readily accessible to all residents and a notice of availability of the results will be prominently posted as evidenced by: 1. The hanging file containing the survey results will be labeled and lowered to a height accessible by wheelchair bound residents. 2. The cover of the notebook containing the survey will reflect the correct date of the survey therein.	10/17/2010

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F 167	Continued From page 4 resident interview, the facility failed to ensure that the results of the most recent survey were accessible to residents as required. Findings were: Observation on 8/30/10 at 8 PM and on all subsequent days of the survey revealed a wooden hanging file located in the hallway near the facility's entrance. The file was unlabeled and was positioned high enough that an individual confined to a wheelchair would not have been able to access the contents of this file. The file contained a notebook. The cover of the notebook was labeled as containing survey results of 8/16/06 and 8/7/08. However, further examination showed the actual contents included the 2009 survey results. Observation on all days of the survey showed no posting of the location of the survey results. Interview with a group of eight cognitive residents on 8/31/10 at 2:30 PM revealed none of the residents were aware of the location of the most recent survey results.	F 167	3. The facility will post signage indicating the location of the survey results. 4. All current and future residents will be informed of the location of the most recent survey results. The Administrator will monitor the accessibility of the most recent survey results and the accuracy and availability of signage pertaining to the date and location of survey results on a monthly basis and report at the quarterly QAA meeting with appropriate follow up.	
F 226 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 226		

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F 225	Continued From page 6 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on personnel record review, the facility did not ensure that 3 of 3 (#2, #3, #4) nurse aides whose records were reviewed had required nurse aide registry checks. The findings were: 1. Review of the personnel record for nurse aide #2 revealed no evidence th Wyoming nurse aide registry was checked prior to her hire on 6/28/10 to determine if this person was listed on the registry and/or had a substantiated findings of abuse, neglect, or misappropriation of resident property 2. Review of the personnel record for nurse aide	F 225	The facility will ensure each new employee will be properly investigated as to abuse, neglect, mistreatment of residents or misappropriation of their property as evidenced by: 1. Prior to employment, any person seeking employment as a certified nurse aid, such as with employee #2, #3, and #4, will have been checked for any history of abuse, neglect mistreatment of residents, or misappropriation of their property on the Wyoming nurse aide registry. The report will be placed in the employee's file. 2. The DON will review all new hire paper work and initial the paper work prior to filing it in the employees personal file. The DON will report at the quarterly QAA meeting with appropriate follow up.	9/02/2010

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F 225	Continued From page 6 #3 revealed no evidence the Wyoming nurse aide registry was checked prior to her hire on 6/3/10 to determine whether or not this person was listed on the registry and/or had a substantiated findings of abuse, neglect, or misappropriation of resident property. 3. Review of the personnel record for nurse aide #4 revealed no evidence the Wyoming nurse aide registry was checked prior to her hire on 6/1/10 to determine whether or not this person was listed on the registry and/or had a substantiated findings of abuse, neglect, or misappropriation of resident property.	F 225		
F 241 05=E	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, medical record review, and family interview, the facility did not ensure dignity in dining for all residents. Multiple residents received a main dish served in bowls with large, visible drips of food down the outsides of the bowls. 1 of 3 (#14) sample residents who were fed by staff did not have his/her mouth or face cleaned of accumulated food in a timely manner in order to enhance the resident's dignity during dining. Findings were: 1. Observation during the evening meal on 8/30/10 at 6:38 PM revealed lots of large food drips down the sides of the bowls containing	F 241	The facility will ensure dignity and respect of individuality will be maintained as evidenced by: 1. The DON will perform random dining room checks to ensure staff is wiping food particles off of resident's mouth and faces with a napkin or washcloth, and to ensure staff do not allow drips of food to accumulate on the outsides of bowls. An in-service will be given on September 23rd, 2010 to instruct staff to wipe food particles off of resident's mouths and faces between bites such as with resident #14, and to wipe food of off the outsides of bowls, such as with multiple residents. The DON will make a written report of the findings of the POC and will report at the quarterly QAA meeting with appropriate follow up.	9/23/2010

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F 241	Continued From page 7 chicken and dumplings. This was particularly noticeable for the residents served the pureed entree. At 6:40 PM resident #34 received his/her plate and bowl. S/he was observed to take his/her spoon and attempt to scrape the drippings from the outside of the bowl and put the food back inside the bowl. 2. Observation during the evening meal between 6:38 PM and 7:25 PM revealed dependent resident #14 was fed by staff. During the observation a number of times an accumulation of food was observed on the resident's face around the left corner of his her mouth and chin. The staff member who was feeding the resident was positioned to the right side of him/her and could not easily see the left side of the resident's face. The staff member attempted to scrape the accumulated food from the resident's face with the spoon periodically, but there were multiple times when the resident sat between bites (while the staff member fed another resident) with accumulated food on his/her face. One of these intervals was two minutes long. Observation of this resident during evening cares at 8 PM showed an accumulation of red gelatin (which was the dessert served) was still visible on the resident's lips and mouth. The resident had been wheeled from the dining room at 7:25 PM, thirty-five minutes prior to the evening cares observation. According to the Minimum Data Set (MDS) assessment for this resident, dated 3/17/10, and the quarterly assessment, dated 6/16/10, this resident was cognitive, but incapable of making her needs known. Interview with a family member on 8/31/10 at 9:45 AM revealed this person, prior to becoming ill, had been "meticulous" about his/her appearance.	F 241		
F 245	483.15(d) PARTICIPATE IN SOCIAL/RELIGIOUS	F 245		

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F 245 38=E	Continued From page 8 ACT/COMMUNITY A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility did not ensure choices concerning activities both in and out of the facility for 4 of 10 sample residents (#11, #38, #5, #25) were respected. Findings were: 1. Interview with the activity director on 9/1/10 at 4 PM revealed that prior to her accident in April while on an Activity outing, resident #11 "used to do everything." The activity director stated the resident had been on an outing to the Senior Center in Big Piney in April 2010. (Nursing notes documentation showed the outing and accident occurred on 4/29/10.) The activity director stated the group of residents who had participated in the outing had their meal and were getting ready to leave the Center when this resident, who was seated in a chair and under the direct supervision of another staff member, stood up and somehow caught the toe of his/her foot on the leg of the chair and fell face first to the floor. The following concerns with the resident's right to participate in activities of his/her choosing were noted: a. Record review revealed resident #11 had admission orders, dated 3/2/10, written by his/her physician that prohibited the resident from participating in the facility's activity program or the volunteer program. Interview on 8/31/10 at 1:30 PM with the consultant social worker for the social	F 245	The facility will ensure each resident will have the right to participate in social, religious, and community activities as evidenced by: 1. The DON will review physician orders such as resident #11, #38, #5 and #25 to ensure physician has not written an order for no participation in activities or volunteer program. If the physician has written an order for no activities or volunteer program, the DON will have him/her clarify the order and re-write to specify what type of activities the resident may participate in. The DON will make a written report monthly and report the findings at the quarterly QAA meeting with appropriate follow up.	9/02/2010

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F 245	Continued From page 9 services department verified the resident had an accident on an outing and that as a result of the accident the resident's physician notified the facility that he had ordered no activities for this resident upon admission, and the resident should never have been allowed to go on an activity outing. b. The activity director stated she was informed after the accident that this resident was not supposed to participate in activities per physician's order. She stated she had not seen the order in the chart. The activity director stated she had not realized there might be a physician's order prohibiting participation in the activities program. The activity director stated this resident - previous to the accident - had participated in all kinds of activities, both in and out of the facility. She stated once the physician and family had notified them of the order, they had immediately complied with the physician's order and did not allow the resident to participate in any activities. c. The activity director stated the facility became very concerned about the psychosocial changes in this resident, and the social worker consultant had contacted the physician to get an order change which would allow some activity participation. d. According to the resident's plan of care as of 8/2/10, which was in effect at the time of the survey, the resident would be allowed to participate in activities in the facility if s/he remained seated, but could not participate in activities outside the facility per physician's order. e. Interview with the resident's son on 9/1/10 at 3:30 PM revealed the resident loved gardening. He also stated the resident did not do anything anymore. When the activity director was interviewed on 9/1/10 at 4 PM she was asked if the current physician's orders meant the resident	F 245		

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F 245	Continued From page 10 could not even be taken out-of-doors in a wheelchair to look at flowers. The activity director responded that, given the physician's orders, she was afraid to take the resident anywhere outside the confines of the facility, even in a wheelchair. f. Observation on all days of the survey showed that even though the resident was present during a number of activities that occurred in the small television room, she did not appear to be interested in the activities and was not an active participant. 2. Medical record review showed the admission physician's orders dated 4/16/10 for resident #36, a closed record, revealed the resident was not to participate in the facility's overall activity plan or volunteer program. Review of the record showed no evidence that this was the resident's choice. 3. Medical record review showed resident #5 had an admission physician's order dated 3/12/10 that documented the resident would not be allowed to participate in the facility's overall activity program. Further record review revealed no evidence this was the resident's preference. 4. Medical record review showed resident #25 had an admission physician's order dated 11/28/08 that documented the resident would not be allowed to participate in the facility's overall activity program. Further record review revealed no evidence this was the resident's preference.	F 245		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing	F 252		

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F 252	Continued From page 11 the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation of 3 of 3 residential wings and staff interview the facility failed to ensure unpleasant odors did not accumulate in the facility. The facility lacked a functional ventilation system. Findings were: Observation during the initial tour on 8/30/10 between 2:30 and 3:40 PM revealed strong fecal odors were apparent on each of the three residential wings in the facility. Interview with the maintenance director on 9/1/10 at 1:30 PM revealed the facility did not have a functional ventilation system in bathrooms or corridors. Observation on 9/1/10 at 1:50 PM showed no ventilation in the bathing room on the 100 hall or in the room known as the main bath. At the time of the observation, the main bath was noted to be full of steam, although there was no one currently in the room, and there was no water in the tub, and the shower was not in use. All mirrors were observed to be fogged up, as was the inside of the cover over the wall-mounted, battery-operated clock.	F 252	The facility will provide a safe, clean comfortable and homelike environment by ensuring unpleasant odors do not accumulate as evidenced by: 1. The facility will consult with an engineering firm to develop plans to install ventilation in the facility in order to remove moisture and foul odors. Residents will be provided timely incontinence care to eliminate odors. 2. The facility will install two ozone generators in both the bathing room on the 100 hall and the main bath to eliminate odors. When the bathing rooms are not in use, all chemicals will be stored in a locked cabinet and the bathing room doors left open to disperse steam and moisture.. 3. The Maintenance Director will track progress of the ventilation project and report at the quarterly QAA meeting with appropriate follow up.	10/17/10
F 278 SS=F	483.20(g) - (i) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278	The facility will ensure accuracy of the MDS assessment as evidenced by: 1. The 6/9/2010 quarterly MDS assessment for resident #24 will be modified to reflect resident #24 had been dressed for the last 7 days of the review period.	9/23/2010

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	535017	A. BUILDING _____ B. WING _____	09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	333 N BRIDGER AVE PINEDALE, WY 82941

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F 278	Continued From page 12 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure MDS assessments were accurate for 1 of 10 sample residents (#24). In addition, the facility failed to ensure the complete time frame for review, based on the assessment reference date (ARD), was met for 10 of 10 sample residents (#5, #7, #11, #14, #21, #22, #24, #25, #33, #38). The findings were: 1. Review of the 6/8/10 quarterly MDS assessment for resident #24 showed section G1g indicated the resident was not dressed for the last seven days of the review period. Interview with	F 278	2. MDS assessments for the Following ten residents #5, #7, #11, #14, #21, #22, #24, #25, #33, #38 showed section R2b was signed the same day as the ARD which means the assessment was completed prior to the end of the ARD date which ends at midnight on the stated date. The MDS coordinator was instructed by the State Surveyor as to the error of R2b date will from this point ensure the R2b date and the ARD date is not the same and the full assessment period will be evaluated. 3. The DON will review the MDS assessment dates to ensure the appropriateness, and the entire assessment period is followed. The DON will give a monthly written report to the Administrator as to the appropriate dates and the DON will report at the quarterly QAA meeting with appropriate follow up.	9/02/2010

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F 278	Continued From page 13 the DON on 9/2/10 at 8:45 AM revealed this was an error in coding. 2. Review of the MDS assessments for the following ten residents #5, #7, #11, #14, #21, #22, #24, #25, #33, #38 showed section R2b was signed the same day as the ARD which means the assessment was completed prior to the end of the ARD date which ends at midnight on the stated date. Interview with the DON on 9/2/10 at 8:45 AM revealed she was unaware of the end of the ARD was at midnight.	F 278		
F 280 0S=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 by:	F 280	The facility will ensure resident care plans will be revised to reflect the resident's current status and needs as evidenced by: 1. Each resident's care plan will be reviewed quarterly at care plans to ensure the care plan reflects the resident's current needs such as with resident #14. If there is a change in status prior to the quarterly care plan meeting the care plan will be revised when the need is identified. The Activity Director will monitor and re-assess and report at the quarterly QAA meeting with appropriate follow up.	9/24/2010

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F 280	Continued From page 14 Based on record review and staff interview, it was revealed 1 of 10 sample residents (#14) did not have a plan of care that was revised to reflect the resident's current status and needs. The findings were: Medical record review revealed the plan of care (reviewed 6/2/10) for resident #14 showed the following goals or approaches that were of concern: a. The activity goal for this resident was that s/he would communicate to activity staff his/her desire to attend three to four activities per week by the next review. This was also the goal for this resident's initial care plan. However, the MDS assessment dated 3/17/10 and the quarterly review of 6/16/10 showed this resident was only sometimes capable of being understood. Further, the MDS showed the resident was incapable of speech and communicated with signs, gestures, and sounds. Observation of the resident on all days of the survey showed s/he did not not verbally communicate with staff or use sign language. The resident made some facial gestures, used eye contact, and some physical gestures. For example, interview with CNA #1 on 9/1/10 revealed this resident could grab a body part to indicate where s/he was having pain and would use his/her hands to help the CNAs when dressing undressing. Interview with the activity director on 9/1/10 at 4 PM verified the current activity goal was not realistic anymore. b. A care plan approach to address issues with activities of daily living (ADLs) included using a clothing protector during the day due to drooling to protect clothes. Observation during all days of the survey revealed this was the only resident who continually wore a full-size clothing protector that covered his/her entire chest and lap when	F 280	2. The care plan for resident #14 will be revised and the use of a clothing protector during the day due to drooling will be eliminated and staff will change resident's clothing as the need arises or should become soiled due to excessive drooling or stains from food particles, etc. 3. The care plan for resident #14 states the resident is to be ambulated with stand-by assist. Resident #14 has been re-evaluated by P.T. and placed on the restorative program and is to be ambulated 4-5 times per week with assist of 2 persons and rest X1 for fatigue. The DON will hold an in-service for staff and inform them of the need for ambulation.	9/23/2010 9/23/2010

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F 280	Continued From page 15 s/he was up. Intermittent observations on all days of the survey showed the resident was not drooling on the clothing protector. Interview with the social services director on 9/1/10 at 9 AM revealed she thought this resident might drool "on occasion." The MDS assessment of 3/17/10 and the quarterly assessment of 6/16/10 showed this resident was cognitive, but could not communicate well. In addition, a family member who was interviewed at 9:40 AM on 8/31/10 stated this resident had always taken a lot of pride in his/her grooming and appearance and, in fact, was described by the family member as being very meticulous about his/her appearance. c. A care plan approach for this resident related to impaired physical mobility was that the resident was to be assisted with ambulation with a walker and stand-by assistance. Interview with [illegible] on 9/1/10 at 2:10 PM revealed the resident no longer ambulated with stand by assistance and a walker. Intermittent observations throughout the survey verified the resident did not ambulate, but was wheelchair dependent. d. The plan of care under problem #1 showed the resident was to receive the tube feeding formula twice a day; however, the same plan of care under problem #12 showed the resident was to receive the tube feeding formula three times per day. The physician's orders on the August 2010 recapitulation (recap) do not show a quantity for the Jevity; however, the July 2010 MAR showed the amount of Jevity 1.2 cal was changed to one can on 7/1/10. The unsigned July 2010 recap still showed the Jevity 1.2 cal was to be given TID (three times daily). The care plan did not reflect these orders. Discrepancies were not identified and clarified so that all individuals would know what the resident's care was to be related to	F 280	4. The care plan for resident will be revised to reflect the amount of Jevity to be given per day by nursing staff. 5. The DON will review each resident's care plan at the quarterly care plan meeting and when physician have been changed to reflect the care they are to receive. The DON will report at the quarterly QAA meeting with appropriate follow up.	9/23/2010

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F 280	Continued From page 16 this tube feeding. When this was discussed with the registered dietician and the dietary manager on 9/1/10 at 12:50 PM they stated the initial order had been for the Jevity to be given 2 to 3 times per day so that there could be some flexibility in adjusting the feeding according to the resident's needs. Their record showed that as of 8/2/10 the resident was receiving two tube feedings per day.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure professional standards were followed in regard to following physician's orders for 2 of 10 sample residents (#7, #14). In addition, the facility failed to ensure staff maintained confidentiality of MARs during 2 of 5 medication pass observations. The findings were: 1. Review of the physician's orders for resident #7 showed an order for Diltiazem CR (antihypertensive) daily at bedtime. Further review of the order showed instructions to call the physician if the systolic blood pressure was less than 80 or the heart rate was greater than 120 beats per minute. Review of the vital sign flowsheet and the MARs for July and August 2010 showed no evidence the blood pressure or heart rate parameters were obtained prior to the daily dose of Diltiazem. Interview with the DON on 9/2/10 at 8:45 AM revealed the vital sign parameters should have been taken prior to each	F 281	The facility will ensure services provided meet professional standards as evidenced by: 1. The MAR for resident #7 will be reviewed randomly and a monthly monitoring sheet will be written as to the BP and P being taking prior to the medication Diltiazem CR being given as set by the physician. The DON will perform the random checks and will report at the quarterly QAA meeting with appropriate follow up.	9/23/2010

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F 281	Continued From page 17 daily dose of medication. 2. Medical record review showed the following professional concerns related to care and services for resident #14: a. The resident had physician's orders per the August 2010 recapitulation (recap) for Jevity 1.2 three times per day (order date shown: 4/28/10). Interview with the registered dietitian and the dietary manager on 9/1/10 at 12:50 PM revealed the care plan showed that since 8/2/10 the resident was receiving Jevity 1.2 twice a day. Review of the MAR revealed the resident was only receiving the Jevity 1.2 once a day (at 2 P.M.. There was no evidence these discrepancies were identified or any attempt to resolve them was made. b. The physician's order recap for August 2010 showed the resident was receive a regular diet of pureed texture served on a three compartment plate. Observation at supper on 8/3010 and breakfast on 8/31/10 revealed the food for this resident was not served on a three compartment plate. 3. Observation on 8/30/10 at 5:10 PM showed RN #1 administered three medications to resident #22 in his/her room. While administering the medications, the RN left the MAR open on the medication cart which allowed others to view the resident's personal information such as birth date, age, allergies, diagnoses, physician orders, and medications. 4. Observation on 8/30/10 at 5:20 PM showed RN #1 entered the room of non sample resident #31 to perform glucose testing. Upon entering the room, the RN left the resident's MAR open on the medication cart where it could be viewed by other	F 281	2. The care plan and MAR has been updated to reflect the correct amount of Jevity 1.2 to be given to resident #14 as well as the care plan. The DON will perform random checks of the MAR, physician orders and care plan to ensure they all coincide with each other the proper care and amount of Jevity is delivered to resident #14. The DON will report at the quarterly QAA meeting with appropriate follow up. The DON and Dietary will give an in-service to nursing staff and dietary staff the care plan for resident #14 must be carried out as written. If nursing staff and dietary staff find the care plan is inappropriate, such as with resident #14 on the use of a three compartment plate being used at each setting, they should notify the Dietary Manager and the DON so the care plan can be changed.	9/23/2010 9/23/2010

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	535017	A. BUILDING _____ B. WING _____ 10/28/10	C 09/02/2010

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F 281	Continued From page 18 residents and the public. The open page showed the resident's diagnoses, allergies, medications, date of birth, and other personal information. 5. Observation on 8/30/10 at 5:5:30 PM showed RN #1 entered the room of resident #7 to administer three medications. The RN left the MAR open on the medication cart where it could be viewed by other residents and visitors. The open page showed personal information about the resident including date of birth, allergies, medications, and diagnoses. 6. Observations on 8/31/10 at 7:55 AM showed licensed practical nurse (LPN) #1 administered medications to non-sample resident #27. Observation revealed the LPN left the resident's MAR open to public and other resident's view. Review of the MAR showed the resident's diagnoses, medications, date of birth and other personal information. Interview with the LPN at that time revealed the MAR should be covered to protect confidentiality.	F 281	4. The DON will give an in-service to nursing staff on ensuring the confidentiality of resident's MARs, such as residents #31, #7, and #27, during medication administration. The DON will perform random checks of medication carts during medication administration to ensure MARS are properly closed and will report at the quarterly QAA meeting with appropriate follow up.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and medical record review, the facility lacked evidence nursing	F 309		

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F 309	Continued From page 19 staff provided the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for 4 of 10 sample residents (#7, #14, #21, #22) who had pain. The findings were: 1. Observation of evening cares for resident #14 on 8/30/10 between 8 and 8:35 PM showed the resident had a red excoriated perineal area. During the observation the resident was noted to grimace and clench his/her teeth while perineal care was being provided. Interview with CNA #1 on 9/1/10 at 2:10 PM confirmed the resident expressed pain by grabbing a body part or by facial expressions. Review of the resident's MDS assessment dated 3/17/10 and a quarterly assessment dated 6/16/10 showed the resident was assessed as having no pain. Review of the resident's current care plan showed a problem identified related to impaired communication. An approach to observe for signs and symptoms of pain was noted for this problem. There was no other problem or approach on the care plan related to pain. Medical record review showed the patient had a pain assessment on 3/4/10. However, there was no evidence of a pain assessment having been completed for this resident since that date. 2. Review of the 6/5/10 quarterly MDS assessment for resident #7 showed s/he experienced moderate stomach and soft tissue pain daily. Review of the medical record showed the most recent pain assessment performed was on 9/8/09. Review of the July 2010 MAR showed pain medication (Lortab or Tylenol) was administered 32 times during the month. A follow-up re-assessment was performed to determine the effectiveness of the pain	F 309	The facility will ensure that care/services for highest well being, will be followed as evidenced by: 1. The care plan for resident #14 will be revised to address pain issues for resident #14 and will have a quarterly pain assessment completed by an RN. The pain management policy will be revised to reflect the pain assessment will be documented in the MAR instead of the current flow sheet in the MAR now. The DON will perform random checks to ensure the care plan addresses any issues of pain for any resident in this facility and will also perform random checks as to the weekly pain assessment being documented. An in-service will be given September 23rd 2010 on the new way of documenting the weekly pain assessment.	9/23/2010

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F 309	Continued From page 20 medication in relieving the resident's pain was performed 6 times. Interview with the director of nursing on 9/2/10 at 8:45 AM revealed her expectation was a follow-up re-assessment within 30 minutes of administering a pain medication. Review of the August 2010 MAR flowsheet showed the resident received pain medication 34 times. Review of this flow sheet also showed a follow-up re-assessment to determine the effectiveness of the pain medication was performed 7 times; in addition, staff did not describe the pain as to intensity or type. 3. Review of the 1/29/10 physician's progress notes for resident #21 showed s/he had headaches every night. Continued review of these notes showed the physician consulted with the resident's neurosurgeon who believed the headaches were not caused by a shunt malfunction. The physician decided to monitor to see if the headaches worsened. Review of the physician progress notes dated 6/11/10 showed the resident continued to complain of daily headaches and the physician noted "we may seek neurologic consultation." Review of the medical record showed no further evaluation or treatment was performed since that time (greater than two months ago). Interview with the resident on 9/2/10 at 8:20 AM revealed s/he continued to have daily headaches. Interview with the director of nursing on 9/2/10 at 8:45 AM revealed she thought the resident had an appointment with a neurologist scheduled. However, interview with the scheduler on 9/2/10 at 10:40 AM revealed there was no appointment scheduled for the resident and she was unaware s/he needed an appointment. 4. Review of the admission face sheet for	F 309	2. The DON will hold an in-service on September 23 2010 to address the issues of documenting the effectiveness of pain relief as for resident #7, 30 minutes after the medication has been given. Resident #7 will have a pain assessment completed by an RN to address the current pain issues for this resident. The DON will perform random chart reviews to ensure pain assessments are being done in timely manner and will report at the quarterly QAA meeting with appropriate follow up 3. The DON addressed the issue of scheduling resident #21 for a neurology consult regarding his/her recurring headaches. Resident #21 has been set up with an appointment on October 27 2010 with a neurologist. A communication form will be given to the scheduler when a physician requests a resident to have an appointment so the scheduler can make the appropriate appointment. If the scheduler is unsure of what type of appointment or who the resident should see, he/she will	9/23/2010 9/02/2010

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F 309	Continued From page 21 resident #22 showed s/he had diagnoses including pain, osteoarthritis, spinal stenosis, spondylosis, and status post arthroscopy. Review of the 4/14/10 initial MDS assessment showed s/he experienced moderate pain daily in his/her muscles. Review of the 8/10/10 pain assessment showed the resident had pain daily in his/her legs and back. The following concerns were identified: a. Review of the current care plan showed pain was not addressed. b. Review of the 7/7/10 quarterly MDS assessment showed the resident's pain was decreased to mild less than daily but the resident continued to receive pain medications almost daily during July and August 2010 according to the MARs. Review of the July 2010 MAR showed the resident received pain medications 26 times but was re-assessed for effectiveness only 8 times. Review of the August 2010 MAR showed the resident received pain medications 27 times and was re-assessed for the effectiveness of the pain medication only 3 times. c. Interview with the DON on 9/2/10 revealed residents should be re-assessed for effectiveness of pain medications within 30 minutes after it was administered.	F 309	notify the DON and a clarification will be received from the physician. The DON will report at the quarterly QAA meeting with appropriate follow up. 4. The DON will also instruct the nursing staff to perform a recheck of the residents pain 30 minutes after giving the resident their pain medications such as with resident #33. The DON will perform random checks to ensure the residents are having their quarterly pain assessments and documentation is followed up on the MAR comments. The DON will report at the quarterly QAA meeting with appropriate follow up	9/23/2010
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced	F 318		

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(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 318	Continued From page 22 by: Based on observation, medical record review, and staff interview, the facility failed to ensure 5 of 10 (#7, #11, #14, #21, #22) sampled residents in need of range of motion (ROM) exercises and restorative ambulation received adequate restorative services. The findings were: 1 Review of the nursing notes for resident #21 showed s/he experienced 21 falls from September 2009 until September 2010. Review of the restorative nursing services care plan dated 10/14/09 showed the resident was to ambulate 150 feet daily with a quad cane and stand by assist as well as receive range of motion (ROM) exercises five times per week. The following concerns were identified: a. Review of the restorative care flow record for July 2010 showed the resident received ROM exercises twice during the week of 7/4 through 7/10/10, none during the week of 7/11 through 7/17/10 and twice during the weeks of 7/18 through 7/24 and 7/25 through 7/31/10. Review of the August 2010 restorative care flow record showed the resident received the appropriate number of ROM exercises during the first two weeks but received ROM only four times during the week of 8/15 through 8/21/10 and only two times during the week of 8/22 through 8/28/10. b. Review of the 8/17/09 and 2/16/10 quarterly MDS assessments for resident #21 showed s/he had functional limitation with partial loss of voluntary movement of the left arm, hand, leg and foot. Review of the 5/19/10 quarterly MDS assessment showed a decline in function to limitation on both sides with partial loss of voluntary movement of the left arm, hand, leg and foot.	F 318	The facility will ensure each resident will have a proper evaluation of their ROM to maintain their current level of functioning or increase their current level of functioning as evidenced by: 1. The DON will review restorative notes randomly to ensure resident's #7, #11, #14, and #22 are receiving ROM exercises and ambulation as written by the P.T. The DON will give a written report to the Restorative Nurse and will report at the quarterly QAA meeting with appropriate follow up. 2. The DON will also review the monthly schedule to ensure there is a restorative aid on the schedule at least 5 days per week to ensure each resident receives restorative care as instructed.	9/23/2010

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F 318	Continued From page 23 2. Review of the 3/24/10 restorative nursing services care plan for resident #14 showed s/he required ambulation to two meals every day with a front wheeled walker and stand by assist. Review of the August 2010 restorative care flow record showed s/he was ambulated only on 8/18, 8/19 and 8/20/10. Periodic observations on all days of the survey showed the resident was not walked to any meal or at any other time. Review of the restorative nurse notes written on 8/23/10 showed the resident had been buckling upon ambulation and now required a two person assist with transfers. Further review shoed ambulation was on hold until the resident's decline in condition was discussed with the physical therapist. Interview with the restorative nurse aide on 9/1/10 at 1:30 PM said she was unaware the resident was on hold for ambulation. She further stated there was no regular communication between her and the restorative nurse regarding changes, just when they saw each other in the hall. During an interview with the restorative nurse on 9/2/10 at 10:07 AM, she confirmed there was no regular meetings with the restorative nurse aides. She also stated there was no regular or periodic evaluations of a resident's restorative care plan. She said, in essence, once the care plan was developed, it was maintained indefinitely unless something big happened and then physical therapy would be consulted to do an evaluation. 3. Review of the restorative nursing services care plan for resident #11 showed she required restorative services including ambulation with a front wheeled walker with stand by assist to all events as well as standing exercises. The care plan did not specify frequency of exercises. Review of the 8/23/10 restorative nurse notes	F 318		

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F 318	Continued From page 24 revealed the resident was unable to ambulate anymore due to an unsteady gait and lack of balance. Further review showed the restorative nurse would discuss the case with physical therapy but as of interview with the restorative nurse on 9/2/10 at 10:07 AM, she had not discussed the resident's decline with a physical therapist. 4. Review of the 4/14/10 initial MDS assessment for resident #22 showed s/he had two falls in the past 180 days. Review of the 7/25/10 nursing notes showed s/he fell backwards and hit his/her back and head. Review of the 8/16/10 nursing notes showed the resident experienced another fall. Review of the 8/17/10 nursing notes showed the resident was "very unsteady" on his/her feet. Review of the fall risk assessments performed on 9/20/09 and 1/1/10 showed the resident was a high fall risk. Review of the restorative nursing services care plan dated 7/12/10 showed the resident was a fall risk and required restorative exercises. The plan included the following: ambulation of 150 feet twice daily using a front wheel walker and stand by staff assistance, sitting hip abductions using theraband, lower quads with resistance as tolerated, ham string curls with theraband, bilateral leg stretches and lateral side steps at the rail for 15 repetitions, his external and abducting kicks for 10 repetitions, and 20 squats. The following concerns were identified: a. Review of the restorative care plan showed no frequency of therapy. Interview with the restorative nurse aide on 9/1/10 at 1:30 PM revealed she just did exercises every day that she worked (Monday through Friday) and did not follow any specific frequency. She further stated that if she was not working, exercises might be performed by a back up restorative nurse aide if	F 318		

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F 318	Continued From page 25 her absence was planned-ahead of time but not always. She also said sometimes the floor CNAs would perform the exercises but there was no set back-up plan for when she was not available. b. Review of the July 2010 restorative care flow record showed the resident was assisted with ambulation and exercises three times during the week of 7/4 through 7/10/10, one time during the week of 7/11 through 7/17/10, three times during the week of 7/18 through 7/24/10 and four times during the week of 7/25 through 7/31/10. Review of the August 2010 restorative care flow record showed the resident received ambulation twice during the week of 7/22 through 7/28/10. Interview with the restorative nurses on 8/2/10 at 10:07 AM revealed the inconsistency of restorative assistance was because the back up restorative nurse aide was not regularly scheduled and filled in only occasionally. 5. Review of the falls risk assessments for resident #7 last performed on 9/18/09 showed s/he was a high fall risk. Review of the restorative nursing services care plan dated 1/24/09 showed the resident required restorative services including ROM and ambulation four to five times per week. The following concerns were identified: a. Review of the July 2010 restorative care flow record showed the resident received three days of restorative services during the week of 7/4 through 7/10/10, once during the week of 7/11/through 7/17/10, three times during the week of 7/18 through 7/24/10. Review of the August 2010 showed the resident received exercises the appropriate number of times during the first three weeks but only twice during the week of 8/22 through 8/28/10.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 26 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 and medical record review, the facility failed to ensure a safe and environment, free from hazards, was maintained for residents. Specifically, 1 of 2 sample residents (#25) who were known to be at risk for elopement had appropriate safety measures in place. Two of nine sample residents (#11, #21) experienced falls without an assessment to determine the cause and contributing factors. One of nine sample residents (#21) obtained unsafe objects. The call cords in 2 of 25 resident bathrooms (#1, #106) were too short. The findings were: In regard to elopement: 1. Review of the 2/15/10 and 5/11/10 elopement assessments for resident #25 showed s/he was an elopement risk. Review of these assessments also revealed even though the resident had a wanderguard on, s/he was able to remove it by cutting it off or by other means of which staff were uncertain. Review of nursing notes and other assessment revealed s/he frequently mentioned s/he wanted to go home. The following concerns were identified: a. Review of the 7/3/10 nursing notes written	F 323	The facility will ensure the environment is free of accident hazards/supervision/devices as evidenced by: 1. The DON will hold an in-service September 23rd 2010 to instruct nursing staff when a resident, such as resident #25, has an increase in behavior certain protocols should be put into place such as sedating the resident in an attempt to calm the resident down or have 1 on 1 staff with the resident. The DON will review resident's chart for signs of escalating behavior and see what interventions were put into place to prevent an elopement or harm to the resident. The DON will report at the quarterly QAA meeting with appropriate follow up.	9/23/2010

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F 323	Continued From page 27 at 2 PM (There was a note indicating this was not the correct date and time but no other date and time was added. According to the incident report the incident occurred on 7/7/10) showed the resident had visited with one of his/her daughters on that day. After the daughter's visit, the resident asked why s/he was in the nursing home and wanted his/her daughter to come and take him/her home. At that time the resident had dressed him/herself in black pants, a black shirt and black shoes. Continued review of these notes showed when the CNA assisted another resident into the bathroom, this resident eloped. The wanderguard was sounding but staff was unable to locate the resident. Staff notified the local police department, the state police, and called in staff to search for the resident. The resident was eventually found near a downtown restaurant. Interview with the social service designee on 9/1/10 at 4:30 PM revealed this resident was known to become agitated after one of his/her daughter's visited. Interview with the DON on 9/2/10 at 8:45 AM revealed staff was aware of the resident's agitation after the daughter's visit but did not increase monitoring or vigilance to ensure the resident did not elope. b. Review of the following nursing notes showed the resident had a history of elopements which was known by staff. Review of the 4/15/10 nursing notes written at 6 PM showed the resident started getting upset at 5:45 PM and kept asking staff why s/he was being held and saying s/he needed to go home. The resident became "very agitated." The resident eloped through the double doors of the resident unit and got as far as the front office before staff were able to bring him/her back to the unit. Review of the 4/21/10 nursing notes written at 12:45 PM showed the resident left the facility and went outside. When a	F 323	2. The DON will form a falls committee that will meet the first Tuesday of every month to review those residents that have had frequent falls, such as resident #21, and interventions to be put into place in an attempt to prevent future falls. The DON will in-service staff on September 23rd 2010. A written report will be done after each fall committee meeting and the DON will report at the quarterly QAA meeting with appropriate follow up.	9/23/2010

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F 323	Continued From page 28 staff member went after the resident the resident refused to return to the building. Two additional staff members went outside and the three of them were able to bring the resident back into the building. Review of the 6/30/10 nursing notes written at 7 PM showed the housekeeper noticed the resident was going outside. Review of the 7/3/10 nursing notes timed at 11 PM showed the resident tried to elope twice that night. c. Review of the following nursing notes written on 8/28/10 at 11 PM showed the resident was again walking the halls and seemed "very upset." Two CNAs witnessed the resident leave the unit and start running. The two CNAs were able to bring the resident back and walked the halls with him/her until 11:25 PM. d. Review of the 6/26/10 care plan showed elopement was identified as a problem. Approaches included assessing the resident for behavioral pattern that trigger elopement attempts and to reduce or eliminate these behavior when possible. In regard in a safe environment and falls: 2. Review of the medical record for resident #21 showed s/he experienced 21 falls over the past year. Falls occurred on 9/18/09, 10/26/09, 11/1/09, 11/3/09, 11/7/09, 12/6/09, 1/19/10, 1/22/10, 2/8/10, 2/10/10, 3/9/10, 3/17/10, twice, 4/29/10, 5/12/10, 6/16/10, 7/6/10, 7/8/10 and 8/26/10. Review of all the incident reports for these falls showed no evidence an assessment of causation and contributing factors was performed in order to prevent additional falls. Interview with the DON on 9/2/10 at 8:45 AM revealed there was no fall team to review falls but the interdisciplinary team looked at them during care plan meetings on a quarterly basis. She further	F 323	2. The DON and the Maintenance Director (MD) will conduct an in-service on the proper procedures for securing sharps, such as resident #21, and other hazardous implements. The DON and MD will conduct random checks of sharps containers and tool carts to ensure they are properly secured and report findings to the quarterly QAA meeting with appropriate follow up.	10/17/2010

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F 323	Continued From page 29 said no formal documented review of falls were performed. Review of the 10/24/09 nursing notes written at 4:30 PM showed resident #21 had wheeled him/herself into the main bathroom and was on the other side of the tub reaching for the sharps container. Review of the 11/20/09 nursing notes written at 10 AM showed the resident was found to have a Leatherman tools with pliers, knife blades "etc." in the pocket of his/her jacket. These items were discovered when staff was looking through the resident's jacket for his/her lighter. Interview with the DON on 9/2/10 at 8:46 AM revealed the resident had taken them from a tool cart that was left unattended in the resident area. 3. Medical record review revealed resident #11, who experienced a fall with injuries on 4/29/10 while on an outing, lacked a subsequent fall assessment. 4. Observation on 9/1/10 at 12:35 PM revealed the call cord for the nurse call system in the bathroom of resident room #1 was too short, in that it did not extend below the level of the toilet paper roll and could not be accessed by a resident from the floor in the event of a fall. 5. Observation in resident room #106 on 9/1/10 at 12:46 PM revealed the call cord in the bathroom was too short. The cord did not extend below the bottom of a towel hanging in the bathroom and was more than 18-inches above the floor, which would limit accessibility to the call system from the floor should a resident fall and be unable to rise.	F 323	3. A resident, such as #11, who experiences a fall with injuries will have a subsequent fall assessment. Interventions will be put in place to prevent future falls. 4. The facility will ensure call cords in resident bathrooms, such as rooms #1 and #106, are long enough to be accessed by a resident who has fallen to the floor and is unable to get up. The MD will install call cords long enough to reach the floors in the bathrooms of rooms #1 and #106. The MD will conduct an in-service instructing staff to immediately report a bathroom call cord that does not reach the floor. The MD will monitor call cords on a monthly basis and report findings to the quarterly QAA meeting with appropriate follow up.	09/23/2010
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 30 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 staff interview and medical record review, the facility failed to ensure the drug regimen was free of unnecessary drugs for 4 of 8 sample residents (#7, #21, #24, #25) who received psychoactive medications. The findings were: 1. Review of physician's orders for resident #7 showed an order dated 1/23/09 for Lexapro 20 mg (milligrams) for depression. Review of the	F 329	The facility will ensure each resident is free from unnecessary medications as evidenced by: 1. The DON receives monthly reports from the Consulting Pharmacist that reviews each resident and the need for a GDR such as with resident #7, #21, #24, #25. The DON will review the reports the Consulting Pharmacist gives to the physicians to ensure each physician has addressed comments made by the Consulting Pharmacist in regards to GDR. If the physician has not addressed the GDR the DON will contact the physician and have him/her address it. The DON will report at the quarterly QAA meeting with appropriate follow up.	9/23/10

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F 329	Continued From page 31 medical record showed no evidence a gradual dose reduction was attempted or contraindicated in the one and one-half years the resident had received the medication. 2. Review of the physician's orders for resident #21 showed the resident had received Lexapro 20 mg for depression since 12/4/08, Trazodone (antidepressant) 100 mg since 11/7/08 and Zyprexa (antipsychotic) 10 mg every morning since 9/25/09 and Zyprexa 5 mg at bedtime since 11/13/09. Review of the medical record revealed no evidence a gradual dose reduction was attempted or contraindicated. 3. Review of the August 2010 MAR for resident #24 showed s/he received Prozac (antidepressant) 40 mg daily and had since 7/19/08. Review of the medical record showed no evidence a gradual dose reduction was attempted or contraindicated. 4. Review of the August 2010 MAR showed resident #26 had received Zoloft (antidepressant) 50 mg since 1/21/09, Exelon (antidepressant) 3 mg twice daily since 2/21/09, and Xanax (antianxiety) 0.5 mg twice daily since 8/17/09. Review of the medical record showed no evidence a gradual dose reduction was attempted or contraindicated. 5. Interview with the DON on 9/2/10 at 8:45 AM revealed the pharmacist reviewed the drug regimen reviews and worked with physicians to monitor medications. She also said the physician's did not always write a response to the pharmacy recommendations.	F 329	2. The DON will also form a psychotropic drug committee to review residents psychoactive drugs in an attempt to reduce any unnecessary drugs. The Psychotropic drug committee will meet on the first Tuesday of every month. The DON will hold an in-service on September 23rd 2010 to in-service nursing staff and will report at the quarterly QAA meeting with appropriate follow up.	
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	F 354		

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F 354	Continued From page 32 Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the nursing schedule, the facility failed to ensure an RN was on duty at least eight consecutive hours, seven days per week for 37 of 37 residents. The findings were: Review of the nursing schedules for July and August 2010 showed there was no RN on duty on the following Saturdays: 7/31, 8/6, 8/14, 8/21 and 8/28/10. During an interview with the DON on 9/2/10 at 8:45 AM, she confirmed there was no RN on those Saturdays.	F 354	The facility will ensure there is a RN on duty 8 consecutive hours 7 days a week as evidenced by: 1. The DON will review the monthly nursing schedule to ensure there is a RN on duty for 8 consecutive hours 7 days a week. The DON will report at the quarterly QAA meeting with appropriate follow up.	9/23/2010
F 441	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.	F 441		

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F 441	Continued From page 33 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility infection control documents and interview with the infection control coordinator, the facility failed to provide adequate and concurrent oversight of the infection control program. The findings were:	F 441	The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection as evidenced by: 1. The Infection Control Coordinator (ICC) will develop a daily log to track potential infections by reviewing the MARS, new physician orders, labs, and interviews with the nursing staff. A similar log will be developed to track employee infections through the managers of each department and the employees themselves. 2. Quarterly monitoring will be done by the ICC, staff development coordinator, RNs, and the DON to ensure safe infection control practices are being followed in the areas of: A. Hand hygiene B. Proper handling of linens C. Peri/catheter care D. Other areas as deemed as deemed necessary for adequate infection control procedures.	9/23/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	C 09/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	953 N BRIDGER AVE PINEDALE, WY 82941

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F 441	Continued From page 34 During an interview with the infection control coordinator on 9/1/10 at 4 PM, it was revealed that she did no surveillance, but relied on nursing staff to let her know of infections. She said sometimes she did not get notified of infections, but would learn of them when calculating the statistical report at the end of the month. She said she did not check for reports of infections on a daily basis, but usually did so once per week. Additionally, there was no log kept concurrently to monitor and track infections for residents or employees. Finally, the infection control coordinator stated she did not conduct or document regular audits of care. She stated spot checks were done now and then. When asked about how many infections were currently in the facility, she said she thought there were three but was unable to identify who the residents were or what the infections were; she said maybe one was a UTI (urinary tract infection).	F 441	A log of the monitoring will be kept by the ICC and staff will be in-serviced on infection control practices. The ICC will meet with the DON and Medical Director on a monthly basis to review the log and will report at the quarterly QAA meeting with the appropriate follow up.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520	The facility will ensure there is an effective quality assurance and performance improvement (QAPI) program in place as evidenced by: 1. The facility will implement QAPI teams to collect and analyze data, develop interventions, and provide follow up in the areas of Pain Management (F309), Falls (F323), Restorative Services (F318), and Unnecessary Drugs (F329). The QAPI teams will meet monthly and report at the quarterly QAA meeting with appropriate follow up.	10/17/2010

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F 520	Continued From page 36 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure there was an effective quality assurance and performance improvement (QAPI) program in place. The findings were: Interview with the administrator and DON on 9/2/10 at 12:18 PM showed the program did not maintain adequate oversight of issues of concern identified during the survey including falls, psychoactive medications, pain management, and restorative services. Interview revealed the QAPI team was unaware of these problems. In addition, the team was unaware of the need for quality improvement projects in addition to the routine established indicators for monitoring. Refer to F309 for concerns regarding pain management. Refer to F323 in regard to resident falls without a comprehensive assessment to determine the cause. Refer to F318 regarding lack of appropriate restorative services. Finally, refer to F329 in reference to unnecessary drugs.	F 520	2. The DON will review Quality Measure indicators, incident reports, and resident charts on a monthly basis to identify additional areas of concern. The DON will report findings to the Administrator each month and report at the quarterly QAA meeting with appropriate follow up.	