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

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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
	525036	A. BUILDING _____ B. WING _____	C 12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 18TH STREET RAWLINS, WY 82301

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADL Activities of Daily Living CAA Care Area Assessment CAT Care Area Triggers CNA Certified Nurse Aide DON Director of Nursing IV Intravenous LPN Licensed Practical Nurse MAR Medication Administration Record MDS Minimum Data Set RN Registered Nurse TAR Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	*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 or 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 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272	**F 272 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** A Comprehensive Assessment was reviewed and updated for Residents #2, #3 #8, and #43 to reflect an in-depth, resident-specific assessment for triggered conditions in terms of the potential need for care plan interventions by the MDS Coordinator and the IDT. The IDT reviewed the RAI Manual referring to Comprehensive Assessments and Care Area Assessments. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** The MDS Coordinator/IDT had conducted an audit to identify residents whose	2/3/12

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

ED 2/3/12

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

This POC accepted & corrections on 2/6/12 @ 1411 per phone conversation with Jane Janus, ED & Betty Nelson, RN State Health Survey coord

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F 272	Continued From page 1 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, and staff interview, the facility failed to provide comprehensive assessments in various areas for 4 of 10 sample residents (#2, #3, #8, #43) whose assessments were reviewed. The findings were: According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, October 2011, "Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions... This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in the MDS data... Use the information	F 272	Comprehensive Assessment triggered for any Care Area Assessment (CAA). Affected residents had their Comprehensive Assessment reviewed by the IDT team. The Care Plan was updated with appropriate interventions where necessary. **MEASURES TO PREVENT RECURRENCE** MDS Coordinator/designee will present completed CAA's triggered from the Comprehensive Assessments to the Interdisciplinary Team (IDT) for review to determine accuracy of the data analysis and the Care Plan for appropriate interventions. **MONITORING QUALITY ASSURANCE** Concerns/inaccuracies identified by the MDS Coordinator/IDT will be presented to the Performance Improvement (PI) Committee for review to determine further corrective action monthly for three (3) months (including residents #2, #3, #8, #43 when applicable) then re-evaluated for further need.	

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F 272	Continued From page 2 gathered thus far to make a clear issue or problem statement." The following concerns were identified: 1. Observation with physical therapy assistant (PTA) #1 on 12/20/11 at 8:60 AM revealed resident #2 had an open wound on the sacral/coccyx area. During the observation, the PTA stated the white area was the resident's "tail bone." Review of the 12/2/11 significant change MDS assessment showed the facility did not code the wound as a pressure ulcer; instead it was referred to as a vascular wound. Review of the attached comprehensive assessment information showed the facility failed to analyze the data to determine the causes and contributing factors leading to development of the wound. Instead, information already identified in the MDS (such as diagnoses and medications) was repeated. 2. According to the 10/8/11 admission MDS assessment, resident #3 was frequently incontinent of bladder. However, observation on 12/19/11 at 3:55 PM showed the resident had an indwelling urinary catheter. During the observation, interview with CNA #1 revealed the catheter was inserted on 12/16/11 to heal a wound on the resident's coccyx. According to Section V (location of comprehensive assessment information), the comprehensive assessment was included in the undated CNA documentation and nursing assessment. Review of that information revealed it was not a comprehensive assessment. In addition, review of the attached Care Area Assessment (CAA) for urinary incontinence showed the facility failed to analyze the data to determine the cause, contributing factors, and impact on the resident.	F 272		

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F 272	Continued From page 3 3. Observation on 12/20/11 at 1:55 PM showed resident #8 was incontinent of urine. Review of the 6/20/11 admission MDS assessment showed the facility determined the resident had frequent urinary incontinence but was not on a toileting program. According to Section V, the comprehensive assessment was included in the undated nursing assessment. Review of that information showed the resident was frequently incontinent. Review of the CAA for urinary incontinence, included with the MDS assessment, revealed the facility documented all the resident's diagnoses and the treatment plan, but failed to analyze the data to determine actual causes, contributing factors, and the impact on the resident. 4. The 12/13/11 significant change MDS assessment for resident #43 was reviewed. This review showed the area of physical functioning was triggered because the resident required extensive or total assistance with all ADLs. Review of the 12/19/11 CAA summary showed the comprehensive assessment for the triggered areas was lacking. 5. After reading some of the comprehensive assessment information on 12/21/11 at 3:20 PM, the MDS coordinator acknowledged she could not identify specific causes for identified problems.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 274	**F 274 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** MDS Coordinator has completed a Significant Change Assessment for Resident #40.	2/3/12

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F 274	Continued From page 4 resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to complete a significant change assessment for 1 of 4 sample residents (#40) who required that type of assessment. The findings were: Review of the 11/7/11 admission MDS assessment for resident #40 showed s/he did not have pressure ulcers and was not at risk for developing them. This assessment also showed s/he did not have swallowing difficulties, had occasional urinary incontinence, required extensive assistance of one with transfers, dressing and toileting, had the ability to eat independently and self propelled his/her wheelchair. According to the assessment the resident weighed 143 pounds and had unsteadiness due to Parkinson's Disease. Review of the medical record for the resident showed the following changes in the his/her condition: increased confusion was noted on 11/17/11, a stage II coccyx pressure ulcer was identified on 12/1/11, his/her weight decreased to	F 274	The IDT reviewed the RAI Manual section regarding Significant Change Assessments. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** The Treatment Nurse and Staff Development Coordinator (SDC) conducted skin checks (including #40) to identify other potentially affected residents. Thirty days of the facility 24-hour Change of Condition Reports and MDS's were re-reviewed by the IDT for potential change of condition. No residents were found to have a potential for a significant change at that time. **MEASURES TO PREVENT RECURRENCE** The SDC conducted an in-service with LN staff on the use of (Situation, Background, Assessment, Request) SBAR and Early Warning Report on 01/05/2011 for identifying/addressing Change of Condition. The SDC will educate newly hired LN's on the use of SBAR. Copies of the SBAR and Early Warning Report completed by LN staff will be provided to the Director of Nursing Services (DNS)/designee. IDT will review SBAR and Early Warning Report information as it is submitted. IDT will	

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F 274	Continued From page 5 139.4 pounds on 11/29/11 and later decreased to 125.1 pounds on 12/6/11, and IV fluids and antibiotics were started on 12/15/11. Review of the nurse's notes, dated 12/10/11 and 12/14 -12/18/11 revealed the resident could no longer eat independently and s/he had a swollen jaw and swallowing difficulties due to problems with his/her teeth. Review of the ADL documentation by the CNAs showed the resident required one person assist with transfers, toileting and dressing in October 2011, but began to require the assistance of two staff to complete the same ADLs after 11/16/11. During an interview on 12/19/11 at 2:48 PM, CNA #2 stated the resident's functional ability and health began to decline "about a month ago" and now s/he was totally dependent on staff for all ADLs. On 12/19/11 at 3:50 PM, RN #1 and the wound care nurse were observed providing care for the resident. At that time a stage III pressure ulcer on the resident's coccyx was observed, and the resident was unable to assist with turning and repositioning. Further observation revealed IV fluids were infusing in the resident's arm and the two nurses provided urinary incontinence care. During the provision of care the two nurses stated the resident's condition had declined and tube feeding placement had been discussed. In an interview on 12/20/11 at 3:45 PM, the MDS coordinator stated the significant change MDS assessment that was needed had not been done because she was not aware of the changes in the resident's condition until 12/19/11.	F 274	conduct a thorough review of the interventions implemented, take further action if needed and complete a Significant Change Assessment if applicable along with appropriate interventions added to the Care Plan and will present them to the PI Committee monthly for review and corrective actions where necessary. IDT will review 24-hour Change of Condition Report with LN staff to identify residents with potential Change of Condition three to four times per week. **MONITORING QUALITY ASSURANCE** The DNS/ designee with the MDS Coordinator will review the facility 24-hour Change of Condition Report for the potential need for further assessment and implementation of a Significant Change Assessment and interventions. Based on the results of the review, additional training and/or corrective actions will be done. Any concerns or corrective actions will be presented to the PI Committee monthly for review and further recommendations. *until resolved*	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	**F 279 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** The Comprehensive Care Plan for Resident #40 has been updated to reflect	2/3/12

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F 279	Continued From page 6 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to develop and implement a care plan that included all of the identified problems for 1 of 10 sample residents (#40). The findings were: Review of the 12/19/11 updated care plan for resident #40, showed staff were to implement preventive skin care interventions, but specific interventions for pressure ulcer care were lacking. Observation on 12/19/11 at 3:50 PM with RN #1 and the wound care nurse revealed the resident had a stage III pressure ulcer on his/her coccyx. In an interview on 12/20/11 at 8:55 AM, the wound care nurse verified the care plan did not include interventions for pressure ulcer care.	F 279	interventions for Pressure Ulcer care ordered by the MD. The IDTreviewed the RAI Manual regarding Comprehensive Care Plans. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** DNS/designee reviewed the care plans for current residents for accurate interventions surrounding residents at risk for skin breakdown and currently receiving treatments as identified from both previous MD orders and the skin assessment completed by the Treatment Nurse and SDC. **MEASURES TO PREVENT RECURRENCE** SDC/designee in-serviced the LN's on the care planning process. The SDC/designee will educate newly hired LN on the care planning process. The Treatment Nurse/designee will complete/update the Care Plans as necessary to include interventions from MD orders and/or changes in skin and/or wound conditions. Any new or changed Care Plans will be presented to the IDT team for review and recommendations. MDS Coordinator to receive weekly clinical reports from DNS/Treatment Nurse/SDC with updated specific information to include new wounds identified and status of current	

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F 279	Continued From page 7 The nurse stated the pressure ulcer was identified on 12/1/11 and the care plan interventions should have been developed at that time.	F 279	resident's w/ wounds. This information will be brought to the IDT for review and analysis to determine if a Significant Change or additional Care Plan interventions are needed.	
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 by: Based on observation, medical record review, and staff interview, the facility failed to revise the care plan to reflect the current status for 1 of 10 sample residents (#2) whose care plans were reviewed. The findings were: An observation and confirmation by CNA #1 on	F 280	MONITORING QUALITY ASSURANCE The DNS/designee will review five (5) Comprehensive Care Plans ~~for residents receiving wound care~~ (including resident #340) weekly for three (3) months then (5) Comprehensive Care Plans monthly. Results of the audits will be reported to PI Committee monthly for review and any corrective action necessary. The PI Committee will then re-evaluate continuation of audits and recommendations made. until resolved bc F 280 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS The Care Plan for Resident #2 has been updated to accurately reflect his/her condition including incontinence and plan of care. IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED MDS Coordinator/IDT reviewed and updated the care plans of current residents to accurately reflect the residents' current status.	2/3/12

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F 280	Continued From page 8 12/19/11 at 4:49 PM revealed resident #2 was incontinent of urine when toileted. At 6:09 PM that day CNA #3 stated the resident usually refused to be toileted so staff just checked and changed the incontinence brief. Review of the resident's care plan revealed instructions that the resident used a urinal and staff were to empty it twice daily. On 12/22/11 at 8:35 AM the DON stated the resident was no longer able to use the urinal. She confirmed the care plan needed to be revised to reflect the resident's current status.	F 280	MEASURES TO PREVENT RECURRENCE The DNS/designee had conducted an in-service with LN staff on completion of bladder status evaluation to identify cause of incontinence, 3-day bladder voiding pattern for initiation as needed, and the care planning of resident's risk factors. The DNS/designee will educate newly hired LN's on the Company Policy and Procedure involving incontinence and the Care Planning Process.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, staff interview, and review of internal investigation information, the facility failed to ensure staff adhered to professional standards of practice related to medication administration. Failure to compare the medication label with the MAR or physician's order affected 1 of 8 residents (#23) observed during medication passes. The same failure affected resident #41 prior to the survey. In addition, a medication was not administered as ordered for resident #40. The findings were: 1. Reference: According to Smith, Duell and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," Seventh Edition, 2008; 580, nurses are to "...check the label three times: a. When taking the medication container from	F 281	Care Plan goals and interventions to be reviewed by IDT for effectiveness and adjusted periodically as needed. MONITORING QUALITY ASSURANCE The DNS/designee will review five (5) care plans weekly (including #2) for three (3) months for accurate reflection of the resident's current status then four (4) care plans monthly. The results of the audits will be reported to PI Committee monthly for review and evaluation of need with corrective actions made where necessary until resolved F 281 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS Resident #23's Cranberry Fruit tablet dose has been corrected to match the Physician's order and MAR.	2/3/12

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F 281	Continued From page 9 storage place. b. When placing medication into medication cup. c. When returning medication container to storage place." Failure to follow this standard of practice was identified as follows: a. Observation on 12/19/11 showed RN #2 prepared and administered medications, including Cranberry Fruit 475 mg, for resident #23 at 4:12 PM. During this observation, the RN did not, at any time, compare the medication label (475 mg was printed in large, dark numbers on the front of the bottle) to the MAR or original physician's order. Reconciliation of the medication pass revealed the physician ordered 600 mg of Cranberry Fruit. Review of the MAR with the RN at 6:12 PM that evening showed instructions to administer Cranberry Fruit, two tablets of 300 mg each for a total of 600 mg. The RN acknowledged she had made an error. b. According to nursing documentation dated 12/1/11 at 10:46 PM, resident #41 received Hydralazine 25 mg instead of Hydroxyzine 25 mg. Review of the facility's internal investigation showed the resident received five (5) doses of Hydralazine from 11/30/11 through 12/1/11 because the nurses did not verify administration of the correct medication. 2. According to the medical record, resident #40 was to receive one gram of IV Rocephin (an antibiotic) twice daily, starting on 12/19/11. However, review of the MAR showed staff only administered one dose that day. On 12/20/11 at 6:20 PM the DON confirmed the antibiotic was administered once on 12/19/11 because the pharmacy did not deliver the second dose.	F 281	Resident #41 has had his/her medication and dosage corrected to match the Physician Order and MAR. Resident #40's medication administration omission cannot be corrected. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** Physician orders were compared to the MAR and medications for current residents to verify accuracy. No inaccuracies were found. **MEASURES TO PREVENT RECURRENCE** The SDC conducted an in-service to LN staff on the Company Policy & Procedure for medication administration process on 01/05/2012. The SDC will educate newly hired LN's on the Company Policy and Procedure for medication administration. **MONITORING QUALITY ASSURANCE** SDC/designee will audit five (5) medication passes per week (including residents #23, #41, and #40) until four (4) consecutive weeks with 100% accuracy then once per week. Results from the audits will be reported to PI Committee monthly for review and evaluation with corrective	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	action taken where necessary. until resolved	

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	535036	A. BUILDING _____ B. WING _____	C 12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	842 16TH STREET RAWLINS, WY 82301

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F 282	Continued From page 10 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of medical records, and staff interview, the facility failed to ensure staff followed the care plans for 9 of 10 sample residents (#2, #3, #8, #17, #23, #28, #40, #43, #53) whose care plans were reviewed. The findings were: 1. According to the care plans, residents #2, #3, #8, #17, #23, #28, and #43 were to have baths or showers once or twice a week. On 12/20/11 at 4:45 PM the DON confirmed the bathing records were the only available documentation of baths/showers for the residents. Review of October through December 21, 2011 bathing documentation showed the seven residents did not consistently received bath/showers once or twice a week. This review revealed there was no record that resident #43 received a bath/shower in December 2011. On 12/21/11 at 4:13 PM CNA #4 stated showers or baths were not done when the facility was short staffed. Observations of resident #43 on 12/20/11 at 9:16 AM and on 12/21/11 at 8:45 AM showed s/he was unshaven and had dirty fingernails. On 12/22/11 at 9:48 AM the administrator verified the lack of a bathing record for resident #43 for the month of December 2011. Staff were unable to provide evidence of a system for ensuring the care plan interventions regarding bath and showers were	F 282	F 282 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS The bath schedule was reviewed with Residents #2, #3, #8, #17, #23, #28 and #43. The bathing/shower schedule and Care Plans were updated to reflect these residents' preference. Resident #40 no longer has an IV and all other residents BD Resident #40's MAR reflects amount of supplement consumed. IV site care/maintenance has been completed for Resident #53 in compliance with IV Policy & Procedure. and all other residents with IVs. The DNS/ED reviewed the shower/bathing schedule and care plans for current residents in the facility on 12/20/11 and Care Plans were updated to reflect these residents'. preference. IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED The ED/designee conducted an audit of the bathing schedule and documentation for the current residents. Omissions and non-compliance was corrected. The audit will be reported at the next PI Committee monthly meeting for recommendations and review, until resolved. BD	2/3/12

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F 282	Continued From page 11 consistently implemented. 2. According to the 12/19/11 updated care plan for resident #40, staff were to implement the following approaches: gain a new IV access every seventy-two hours "per policy", record the amount of supplement the resident consumed, and complete skin checks according to the facility's policy for weekly skin checks. Evidence of the facility's failure to consistently follow the care plan was identified as follows: a. Review of the November and December 2011 TAR showed the resident's IV access had been placed on 12/15/11 and was scheduled to be changed on 12/18/11. On 12/19/11 at 9:50 PM, RN #1 and the wound care nurse were observed changing the IV access from the left arm to the right arm. At that time RN #1 confirmed the IV access should have been changed on the previous day, but it was "overlooked". b. Review of the November and December 2011 MAR and food consumption records showed no documentation of the amount of supplement the resident consumed. c. Review of the December 2011 weekly pressure ulcer condition report showed the assessments were completed on 12/1/11 and 12/19/11, but not on 12/8/11 and 12/15/11. d. On 12/20/11 at 8:55 AM, the wound care nurse confirmed the supplement documentation and weekly skin assessments had not been implemented according to the care plan. The nurse also stated both interventions were important in the management of pressure ulcer care for this resident. 3. According to the care plan for resident #53, the	F 282	MEASURES TO PREVENT RECURRENCE The ED in-serviced staff on 01/05/2012 on the updated bathing schedule and following the residents Care Plan for bathing and personal hygiene care. Newly hired staff will be educated by the SDC during orientation.	

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F 282	Continued From page 12 dressing on his/her central venous access intravenous catheter needed to be changed weekly. Review of the October, November and December 2011 TAR showed the intravenous catheter was inserted on 10/17/11 and the dressing was changed on 10/23 and 10/24/11. Further review showed the dressing changes had not been performed in November and December 2011. Interview with the DON and administrator on 12/20/11 at 7:45 PM confirmed staff failed to perform the dressing changes after 10/24/11.	F 282	resident MAR/TAR who receives an order for IV medications for compliance with IV site care/maintenance in accordance with Policy and Procedure until the IV is discontinued by MD order. The results of the monitoring will be presented to the PI Committee for review or corrective actions until the IV is discontinued by MD order.	
F 309 SS=E	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, record review and staff interview the facility failed to develop a wound care program that included a comprehensive, consistent method for ensuring professionals; were immediately notified of skin issues, initiated appropriate treatment of wounds, followed physician's orders for daily dressing changes, and accurately documented treatment results. The lack of an effective wound care program affected 3 of 5 sample residents who required this type of care (#2, #3, #53). The findings were: 1. Observation with physical therapy assistant	F 309	The DNS/designee will audit five (5) resident's MARs weekly (including #40) that are receiving supplemental nutrition for documentation of amount consumed for three (3) months then monitor the MARs weekly thereafter. The results of the audits and monitoring will be reported to PI committee monthly for review and evaluation with corrective actions as necessary. **F 309 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** The Treatment Nurse is overseeing the wound care program. Residents #2, #3 and #53 are receiving an appropriate treatment of wounds and according to the Physician Orders; accurate documentation and care plans are updated to reflect current individualized wound care status.. Resident #53's IV is flushed and the dressings changed in accordance with IVsite care and maintenance Policy & Procedure and the Care Plan has been updated.	2/3/12

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F 282	Continued From page 12 dressing on his/her central venous access intravenous catheter needed to be changed weekly. Review of the October, November and December 2011 TAR showed the intravenous catheter was inserted on 10/17/11 and the dressing was changed on 10/23 and 10/24/11. Further review showed the dressing changes had not been performed in November and December 2011. Interview with the DON and administrator on 12/20/11 at 7:45 PM confirmed staff failed to perform the dressing changes after 10/24/11.	F 282		
F 309 SS=E	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, record review and staff interview the facility failed to develop a wound care program that included a comprehensive, consistent method for ensuring professionals; were immediately notified of skin issues, initiated appropriate treatment of wounds, followed physician's orders for daily dressing changes, and accurately documented treatment results. The lack of an effective wound care program affected 3 of 5 sample residents who required this type of care (#2, #3, #53). The findings were: 1. Observation with physical therapy assistant	F 309	**F 309 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** The Treatment Nurse is overseeing the wound care program. Residents #2, #3 and #53 are receiving an appropriate treatment of wounds and according to the Physician Orders; accurate documentation and care plans are updated to reflect current individualized wound care status.. Resident #53's IV is flushed and the dressings changed in accordance with IVsite care and maintenance Policy & Procedure and the Care Plan has been updated. The Care Plans for residents with actual and potential for skin integrity issues have been updated to reflect preventative interventions and current treatment consistent with MD orders.	2/3/12

and all resident other resident with wounds

as has all residents with IVs

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F 309	Continued From page 13 (PTA) #1 on 12/20/11 at 9:50 AM showed resident #2 had an open wound on the coccyx, black eschar on the left heel, and black to yellowish eschar on the right ankle. The resident also had two areas of eschar on the anterior aspect of the left lower leg. Even though the wounds were in locations normally associated with pressure ulcers, according to the 12/2/11 MDS assessment, all were determined to be of vascular origin. Review of the bathing and skin check records showed they were not completed as care planned. Review of the wound documentation showed staff had identified the wound sites incorrectly and were recording measurements of wounds where none existed. Further review showed measurements were not routinely recorded and documentation of each wounds' progress and appearance was lacking. On 12/20/11 at 3:15 PM, the wound care nurse and the DON confirmed the documentation was incorrect, then the wound care nurse corrected the forms. 2. On 12/20/11 at 10:10 AM observation revealed resident # 3 had an open area on each upper buttock in the sacral/coccyx area. Review of the 10/1/11 admission nursing assessment showed staff documented "...dryness to sacral/coccyx area, healing skin issue." On 10/10/11 nursing documentation indicated the residents buttocks/coccyx were very red and excoriated. Orders were obtained to cleanse the area with Sea Cleanse and apply a thin coat of Nystatin cream and microguard powder three times daily until healed. Further review showed the orders were changed on 10/17/11, 10/21/11, 10/24/11, 11/29/11, 11/30/11, 12/9/11, and 12/16/11. However, there was no documentation to show	F 309	**IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** An audit by the Treatment Nurse and SDC included skin assessments and 100% completion of Braden Scale for current residents. Preventative interventions were implemented and care plans updated to reflect changes identified from audit. The results of the audit will be reported to the PI Committee for review and corrective action where necessary until resolved Bi **MEASURES TO PREVENT RECURRENCE** Treatment Nurse and SDC In-serviced LN on Wound Care Program and IV Policy & Procedure on 01/05/12. Newly hired LN staff will be educated on the Policy and Procedures during orientation. Treatment nurse will attend the weekly skin meeting to review the care plans of the current residents receiving wound/dressing changes with the IDT, to include MDS Coordinator, regarding the progress/effectiveness of current treatment. Treatment nurse will consult with MD for wound care intervention changes as needed and the Care Plans updated accordingly. **MONITORING QUALITY ASSURANCE** The DNS/designee will audit four (4) charts weekly(including #53, #2, and #3) for the	

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F 309	Continued From page 14 whether the treatments were effective, what the wounds looked like, or what the measurements were. On 12/20/11 at 4 PM the wound care nurse stated that the documentation in the treatment book was all that was available. 3. Review of the 10/17/11 physician's orders for care of the central venous access intravenous catheter for resident #53 included instructions for the dressing to be changed weekly. Review of the October, November and December 2011 TAR showed the intravenous catheter was inserted on 10/17/11 and the dressing was changed on 10/23 and 10/24/11. Further review showed the dressing changes had not been performed in November and December 2011. Interview with the DON and administrator on 12/20/11 at 7:45 PM confirmed staff failed to perform the weekly dressing changes after 10/24/11. 4. On 12/20/11 at 3 PM the DON stated that the wound care program has problems with assessments, documentation, and lack of consistency. She also stated that the wound care nurse has only had the position since 12/16/11. During an interview on 12/21/11 at 3:40 PM, the administrator stated the previous wound care staff left in October, and since that time no one specific person ran the program. Both he and the DON acknowledged the program was currently "in shambles."	F 309	completion of documentation of wound care in accordance with Company Policy & Procedure for three (3) months then four (4) charts monthly. The results of the audits will be presented to the PI Committee for review and evaluation with corrective actions if necessary, until resolved. BV The DNS/designee will monitor compliance of IV care/maintenance (including #53) in accordance with Company Policy & Procedure four (4) times per week on residents who receive an MD order for IV medications until the IV site is discontinued by an MD order. Results of the audits will be reported to PI Committee monthly for review and evaluation with corrective actions where necessary, until resolved. BV	2/3/12
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F 312 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS The bath schedule was reviewed with all BV Residents #2, #3, #8, #17, #23, #28 and #43. The bathing/shower schedule and including BV	

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F 312	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure staff provided appropriate perineal (incontinence) care for 1 of 7 residents (#2) observed during provision of that care. In addition, the facility failed to ensure scheduled baths and showers were consistently provided for 7 of 10 sample residents (#2, #3, #8, #17, #23, #28, #43) who required assistance with activities of daily living. The findings were: 1. Observation on 12/19/11 at 4:49 PM showed resident #2 was being toileted by CNAs #1 and #3. During the observation, CNA #1 confirmed she could see the lines on the resident's incontinence brief, indicating the resident had been incontinent of urine prior to being toileted. CNA #3 cleansed the resident's posterior perineum but failed to cleanse the anterior groin and genitalia of urine. At 5:09 PM that day CNA #3 verified she did not cleanse the anterior groin and perineum and confirmed that was not the accepted practice. 2. Observations of resident #43 on 12/20/11 at 9:15 AM and on 12/21/11 at 8:46 AM showed s/he was unshaven and had dirty fingernails. In an interview on 12/20/11 at 11:05 AM, LPN #1 stated showers/baths were provided on the first and second shifts and scheduled one to two times weekly. She stated the CNAs had been instructed to document the reason when the bath/showers were not done according to the	F 312	Care Plans were updated to reflect these residents' preference. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** The ED/designee conducted an audit of the bathing schedule and documentation for the current residents. Omissions and non-compliance was corrected. The audit will be reported at the next PI Committee monthly meeting for recommendations and review, until resolved. **MEASURES TO PREVENT RECURRENCE** SDC/designee to complete nursing in-service on Perineal Care for nursing staff. The SDC will educate newly hired nursing staff on the Company Policy and Procedure regarding Perineal Care during orientation. The ED in-serviced staff on 01/05/2012 on the updated bathing schedule and following the residents Care Plan for bathing and personal hygiene care. The SDC will educate newly hired staff on the Company Policy and Procedure. **MONITORING QUALITY ASSURANCE** The DNS/designee will audit ten (10) ADL flow sheets (including #2, #3, #8, #17, #23, #28, #43) 3x/week for one month then weekly for documentation that residents received their bath/shower and personal hygiene care per his/her care plan. The	

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F 312	Continued From page 16 schedule. On 12/21/11 at 4:13 PM CNA #4 stated showers and baths were not done when the facility was short staffed. Review of the October through December 21, 2011 bath and shower records for residents #2, #3, #8, #17, #23, #28, and #43 revealed none of the seven residents consistently received showers/baths one to two times a week, and there was no record that resident #43 received a bath/shower in December 2011. On 12/20/11 at 4:45 PM the DON confirmed the bathing records were the only available documentation of baths/showers for the residents. On 12/22/11 at 9:48 AM the administrator verified the lack of a bathing record for resident #43 for the month of December 2011. Review of the medical records for residents #2, #3, #8, #17, #23, #28, and #43 revealed all required assistance with bathing and personal hygiene care.	F 312	results of the audit will be presented to the PI Committee for review and evaluation with corrective action where necessary, until resolved BD	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 314	**F 314 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** On 12/23/11, Resident #40 had an effective wound care program initiated, which contains physician's orders for dressing changes with an appropriate treatment and documentation. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** An audit by the Treatment Nurse and SDC included skin assessments and 100%	2/3/12

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F 314	Continued From page 17 staff interviews and review of policies and procedures, the facility failed to implement measures in a timely manner to prevent the develop of pressure ulcers, and failed to provide consistent monitoring, assessments and treatments for 1 of 1 sample resident (#40) who developed a facility acquired avoidable stage III pressure ulcer. This failure resulted in actual harm for the resident. The findings were: Review of the 11/7/11 admission MDS assessment for resident #40 showed s/he did not have pressure ulcers and was not at risk for developing them. This assessment also showed s/he required extensive assistance of one with transfers, dressing and toileting, was unsteady due to Parkinson's Disease, had the ability to eat independently, and self propelled his/her wheelchair. Review of the corresponding care plan, updated 12/19/11, revealed staff interventions that included; assist with ADLs, record the amount of supplement the resident consumed, and complete skin checks according to the facility's policy for weekly skin checks. Review of the 11/9/11 nurse's notes showed there was an area of redness on the resident's anus and coccyx. Review of the December 2011 weekly pressure ulcer condition report showed staff noted a stage II pressure ulcer on the sacrum and coccyx on 12/1/11. The report also showed the length times the width of the pressure ulcer was less than four square centimeters, the undermining was less than two centimeters and there was no visible necrotic tissue or drainage. Review of the medical record showed the physician ordered the following treatment on 12/1/11: "Cleanse open areas on the coccyx with Sea Cleans, then apply Sebasorb, cover with	F 314	completion of Braden Scale for current residents. Preventative interventions were implemented and care plans updated to reflect changes identified from audit. The audit was presented to the PI Committee for review and corrective actions where necessary. MEASURES TO PREVENT RECURRENCE Treatment Nurse and SDC in-serviced LN on Wound Care Program and IV Policy & Procedure on 01/05/12. Newly hired LN staff will be educated on the Wound Care Program and IV Policy and Procedure by the SDC/designee during orientation. MONITORING QUALITY ASSURANCE Treatment nurse will attend the weekly skin meeting to review the care plans of the current residents receiving wound/dressing changes with the IDT, to include MDS Coordinator, regarding the progress/effectiveness of current treatment. Treatment nurse will consult with MD for wound care intervention changes as needed and update the Care Plans as appropriate. The DNS/designee will audit three (3) charts weekly (including #40) for the completion of documentation of wound care, to include weekly pressure ulcer condition report and weekly skin assessments in accordance with Company	

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F 314	Continued From page 18 foam pad with paper tape. Change every day." Further review showed the physician ordered IV fluids and antibiotics on 12/16/11 because the resident had problems with his/her teeth. Review of the 12/19/11 weekly pressure ulcer condition report showed the length times the width of the pressure ulcer increased to four to sixteen centimeters, the area was draining thin watery pale red/pink drainage, and 25% to 50% of the area had visible necrotic tissue. Review of the medical record showed periodic RD assessments and recommendations for supplemental nutrition to address the resident's weight loss. During an interview on 12/19/11 at 2:46 PM, CNA #3 stated the resident's functional ability and health began to decline "about a month ago" and now s/he was totally dependent on staff for all ADLs. On 12/19/11 at 3:50 PM, RN #1 and the wound care nurse were observed providing care for the resident. At that time a stage III pressure ulcer on the resident's coccyx was observed, and the ulcer had areas of necrotic tissue and pink/red drainage. The following concerns were identified regarding the facility's failure to provide the skin care this resident needed: a. Review of the December 2011 weekly pressure ulcer condition report showed the assessments were completed on 12/1/11 and 12/19/11, but not on 12/8/11 and 12/15/11. During an interview on 12/21/11 at 10:15 AM the administrator stated he had no explanation for why the weekly assessments had not been done. b. Review of the December 2011 TAR documentation and interview on 12/20/11 at 8:02 AM with the wound care nurse revealed the daily treatments were not done on 12/1, 12/2, 12/8, 12/10, 12/14 and 12/15.	F 314	Policy & Procedure for three (3) months then four (4) charts monthly. The results of the audit will be presented to the PI Committee for review and evaluation with corrective action where necessary, until resolved by The DNS/designee will audit five (5) TARS weekly (including) for a month, then weekly for evidence of completion of daily treatments. The audits will be presented to the PI Committee monthly for review and evaluation with corrective action where necessary. until resolved by	

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F 314	Continued From page 19 c. Review of the weekly pressure ulcer condition report documentation showed the continued deterioration in the pressure ulcer, however, review of the December 2011 TAR and interview on 12/20/11 at 8:02 AM with the wound care nurse revealed the same treatment was continued from 12/1/11 to 12/20/11 (twenty days) without an assessment of the effectiveness of the treatment. d. On 12/20/11 at 8:55 AM, the wound care nurse stated staff provided nutritional supplements for the resident, but it was difficult to assess the effectiveness because staff failed to document the amount, if any, the resident consumed. e. During an interview on 12/20/11 at 4 PM, the administrator stated the resident's pressure relieving mattress was replaced with a special pressure relieving air flow mattress earlier that day (nineteen days after the stage II pressure ulcer was first identified). He stated this mattress would be more effective in reducing pressure for the resident. He further stated there was a delay in implementing the change in the pressure relieving mattress because staff had not reported the resident needed it until last week. f. Interview on 12/20/11 at 3:46 PM with the MDS coordinator revealed she had not received information regarding the changes in the resident's condition until 12/19/11, therefore, the significant change MDS assessment that was needed had not been done. g. Review of the care plan revealed interventions that addressed pressure ulcer prevention, however interventions for the care of the existing pressure ulcer were not included. In an interview on 12/20/11 at 8:55 AM, the wound care nurse verified the care plan did not include	F 314		

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F 314	Continued From page 20 interventions for pressure ulcer care. The nurse stated the pressure ulcer was identified on 12/1/11 and the care plan interventions should have been developed at that time. The nurse also stated he was in the process of revising the facility's pressure ulcer care program because currently the facility did not have a systematic approach for determining effective measures, identifying contributing factors, and ensuring treatments were done as ordered. Review of the policy entitled "Pressure Ulcer Prevention", POL 614, 4/28/09, revealed the policy included the following compliance guidelines: "1. Identify residents at risk for pressure ulcer development upon admission within six hours, then weekly for an additional four weeks...and... with significant change in condition or functional status. 2. Identify clinical conditions that are the primary risk factors for developing pressure ulcers... 10. Monitor the impact of the interventions, and modify the interventions as appropriate... 12. Evaluate and individualize use of various devices to reduce or relieve pressure and/or reduce skin injuries that may result in pressure ulcers... 17. Assess resident from head to toe for skin and effectiveness of care plan interventions and document in the resident's medical record."	F 314		2/3/12
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353	F 353 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS On 12/23/11, Residents #2, #3, #8, #17, #23, #28 and #43 in addition to all remaining current residents were placed on a bath /shower schedule and adequate staffing per staffing patterns to meet the resident's needs, per shift scheduled.	

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F 353	Continued From page 21 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to ensure adequate staff were assigned to provide bathing and showering needs for 7 of 10 sample residents (#2, #3, #8, #17, #23, #28, #43). The findings were: Observations of resident #43 on 12/20/11 at 9:15 AM and on 12/21/11 at 8:45 AM showed s/he was unshaven and had dirty fingernails. In an interview on 12/20/11 at 11:05 AM, LPN #1 stated showers/baths were provided on the first and second shifts and scheduled one to two times weekly. She stated the CNAs had been instructed to document if when the bath/showers were not done according to the schedule. Review of the October through December 21, 2011 bath and shower records for residents #2, #3, #8, #17, #23, #28, and #43 revealed none of the seven	F 353	Baths/showers for these residents are provided according to the Care Plans. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** A review of the current bath/shower schedule was done by the ED to determine if residents were included on the schedule. Residents were added as needed and the schedule was placed in the ADL book. The results of the review will be reported to the PI Committee monthly meeting. **MEASURES TO PREVENT RECURRENCE** DNS and LN staff received education on staffing patterns to meet the resident's needs by the SDC. **MONITORING QUALITY ASSURANCE** DNS/designee will review staffing schedule three (3) to five (5) times a week with ED to determine if staffing needs are met for one year. Any staffing concerns will be addressed at that time and then presented to the PI Committee monthly for review and evaluation with corrective action where necessary, until resolved bw The DNS/designee will audit the ADL flow sheets 3x/week (including residents #2, #3, #8, #17, #23, #28, #43) for one month then weekly for documentation that residents bw	

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F 353	Continued From page 22 residents consistently received showers/baths one to two times a week, and there was no record that resident #43 received a bath/shower in December 2011. On 12/20/11 at 4:45 PM the DON confirmed the bathing records were the only available documentation of baths/showers for the residents. On 12/22/11 at 9:48 AM the administrator verified the lack of a bathing record for resident #43 for the month of December 2011. On 12/20/11 at 1:55 PM CNA #4 stated the staffing shortage usually occurred on the second shift and sometimes the CNAs were unable to perform all of the scheduled showers and baths. On 12/21/11 at 4:04 PM CNA #2 stated that since November 2011 there were times when only four CNAs were scheduled on the second shift instead of the five that were needed to provide the care the residents needed. Interviews on 12/21/11 at 4:40 PM with CNA #5 and at 4:50 PM with CNA #8 revealed the lack of sufficient staff during the second shift impacted resident care in the following manner: staff had no time to visit with residents or bring them out for social activities, scheduled baths/showers were not done, and food consumption records were not completed. Interviews with two randomly selected residents (#1, #21) on 12/22/11 from 9 to 9:15 AM revealed there were times when the residents did not receive their scheduled showers and baths. During the interviews, the two residents revealed they did not like it when they did not receive scheduled showers/baths, but they did not complain because they knew it only happened when staffing was inadequate. Interview with the the administrator on 12/19/11 at	F 353	received their bath/shower per his/her care plan. Results of the audits will be reported to PI committee monthly for review and evaluation with corrective action where necessary.	

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F 353	Continued From page 23 1:40 PM and with the DON on 12/22/11 at 8 AM verified that at least five CNAs were needed to meet the needs of the residents on the second shift. During the interview with the DON, she stated the facility had reoccurring problems with scheduling adequate numbers of CNAs for the second shift. On 12/22/11 at 8:15 AM the staffing schedules for October, November and December 2011 were reviewed with the DON. At that time she verified the lack of adequate staff for the second shift on fourteen of thirty-one days in October, ten of thirty days in November, and nine of twenty-two days in December.	F 353		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F 425 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** Resident #23's Cranberry Fruit tablet dose has been corrected to match the Physician's order and MAR. Resident #41 has had his/her medication and dosage corrected to match the Physician Order and MAR. Resident #40's medication administration omission cannot be corrected. Facility currently obtains services of a licensed Pharmacist. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** Physician orders for current residents were compared to the MAR and medications to verify accuracy. Changes were made were necessary.	2/3/12

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F 425	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop and implement an effective system to ensure routine and emergency medications were available for administration as ordered. This failure affected 2 of 10 sample residents (#23, #40) and one supplemental resident, (#41). The findings were: 1. According to nursing documentation dated 12/1/11 at 10:45 PM, resident #41 received Hydralazine 25 mg instead of Hydroxyzine 25 mg. Review of the facility's internal investigation showed the facility received Hydralazine instead of Hydroxyzine from the pharmacy and staff administered the wrong medication to the resident. Further review of the investigation showed the facility developed a plan to prevent recurrence of this event. 2. Observation on 12/19/11 showed the facility's above mentioned action plan was ineffective in preventing medication errors. RN #2 prepared and administered Cranberry Fruit 475 mg, for resident #23 at 4:12 PM. Reconciliation of the medication pass revealed the physician ordered 600 mg of Cranberry Fruit. Interview with the administrator and DON on 12/20/11 at 4:15 PM revealed a nurse picked up the medication on the weekend from the secondary pharmacy. However, the facility failed to ensure the correct medication was obtained. 3. According to the medical record, resident #40 was to receive one gram of IV Rocephin (an antibiotic) twice daily, starting on 12/19/11.	F 425	MEASURES TO PREVENT RECURRENCE The SDC in-serviced the LN staff on medication administration process on 01/05/2012. The IDT has reviewed the back up pharmaceutical process and found it appropriate. The DNS/designee has in-serviced LN on back-up pharmaceutical services for receiving routine and emergency medications as ordered. MONITORING QUALITY ASSURANCE SDC/designee will audit five (5) medication passes per week until four (4) consecutive weeks with 100% accuracy then once per month. The results of the audit will be reported to PI Committee monthly for review and evaluation with corrective actions necessary, until resolved.	

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F 425	Continued From page 25 However, review of the MAR showed staff only administered one dose that day. On 12/20/11 at 6:20 PM the DON confirmed the antibiotic was administered once on 12/19/11 because the pharmacy did not deliver the second dose.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**F 441 CORRECTIVE ACTION FOR IDENTIFIED RESIDENTS** SDC provided ~~1:1 in-service with Treatment Nurse (RN)~~ and LN staff on Procedure for Hand Hygiene/ Washing on 1/11/12 affecting Resident #40. SDC in-serviced LN staff on the Company's/Policy and Procedure for the Blood Glucose Cleaning Procedure on 01/05/12 affecting Resident #30. The SDC will educate newly hired LN staff on the Procedure for Blood Glucose Cleaning during orientation. **IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED** The SDC and DNS conducted wound and skin rounds with the Treatment Nurse to determine if other residents were affected. Education was given and corrective actions taken when necessary. The results of the rounds will be reported at the next PI Committee monthly meeting. **MEASURES TO PREVENT RECURRENCE** SDC provided 1:1 in-service with	2/3/12

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	642 10TH STREET RAWLINS, WY 82301

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F 441	Continued From page 26 (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 the manufacturer's instructions, Centers for Disease Control & Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings, and staff interview, the facility failed to ensure staff implemented appropriate infection control practices. This failure affected 1 of 4 sample residents (#40) whose dressing changes were observed. In addition, an inappropriate cleaning technique was utilized after use of a glucometer (machine for obtaining blood sugar test results) for resident #30. The findings were: 1. On 12/19/11 at 3:50 PM RN #1 and the wound care nurse were observed providing pressure ulcer care for resident #40. During the observation, the wound care nurse completed the treatment and dressing change, then proceeded to perform additional tasks without removing his gloves or performing hand hygiene. Continued observation revealed the wound care nurse had contact with the resident's IV site, back, shoulders, face, and bed linen prior to removing his gloves. After he removed his gloves he provided oral care for the resident. During an interview with the wound care nurse on 12/20/11 at 8:05 AM he acknowledged that performing multiple tasks without hand hygiene and not performing hand hygiene after removing his	F 441	Treatment Nurse (RN) and LN staff on Procedure for Hand Hygiene/ Washing affecting Resident #40 and current residents.. SDC in-serviced LN staff on the Company's Policy and Procedure for the Blood Glucose Cleaning Procedure on 01/05/12 affecting Resident #30 and current residents with an MD order for glucose checks. The SDC will educate newly hired LN staff on the Procedure for Blood Glucose Cleaning during orientation. The SDC/designee educates newly hires on the Procedure for Hand Hygiene/Washing and the Procedure for Clean Dressing Change during orientation ~~by the SDC/designee.~~ Newly hired staff will be educated on the Procedure for Hand Hygiene/Washing by the SDC during orientation. MONITORING QUALITY ASSURANCE SDC/designee will monitor three (3) wound dressing changes per week (including #40) for one month then one weekly. The results will be presented to the PI Committee for review and evaluation with corrective action where necessary until resolved SDC/designee will monitor three (3) Blood Glucose Monitoring/Cleanings weekly for one month (including #30) then one weekly. The results will be presented to the PI Committee for review and evaluation with corrective action where necessary until resolved	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	566036	A. BUILDING _____ B. WING _____	C 12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 27 gloves was not an acceptable standard of infection control practice. The Centers for Disease Control & Prevention (CDC) Guideline for Hand Hygiene in Health-Care Settings, published in Mortality & Morbidity Weekly Report, RR-16, October 25, 2002, pp 32-33, strongly recommends healthcare workers perform hand hygiene after contact with patients [residents], after contacting environmental surfaces in the vicinity of the patient, before and after potential contact with non-intact skin [such as a wound], and after removing gloves. 2. Observation on 12/19/11 at 4:16 PM showed RN #2 used a glucometer to perform a fingerstick blood sugar test for resident #30. During the observation, the RN set the case holding the glucometer on the overbed table but left the glucometer inside it. After obtaining the test results, the RN removed the case from the room but,without cleaning it, set it on top of the medication cart. The RN then cleansed the glucometer with a SaniCloth Plus wipe, immediately replaced it into the case, and placed the entire case into a medication cart drawer. Review of the manufacturer's instructions printed on the label of the container of SaniCloth Plus showed: "To disinfect nonfood contact surfaces only: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three (3) minutes. Use additional wipes if needed to assure continuous three (3) minute wet contact time. Let air dry." On 12/22/11 at 9:55 AM the DON stated staff were to use alcohol to clean the glucometer then wipe it down with a SaniCloth Plus wipe. The	F 441	SDC/designee will monitor five (5) staff members weekly for proper hand washing technique weekly. The results will be presented to the PI Committee for review and evaluation with corrective action where necessary, until resolved. BV	

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F 441	Continued From page 28 DON further stated she was unaware of the three minute wet contact time required by the manufacturer.	F 441		