JR 6/14/05

PRINTED: 05/31/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535017	A. BUILDING _____ B. WING _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 699 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 246 SS=B	483.15(e)(1) QUALITY OF LIFE A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on one staff and resident interview, the facility failed to provide eight resident's with prompt assistance via the call light system.. The facility census was 37. The findings were: Confidential resident interviews were conducted on 5/17/05 between 9 AM and 2 PM with residents. The interviews revealed call lights were not answered timely, and the residents had to wait for assistance. Seven residents stated, "Call lights are answered in a shorter period of time now that the state surveyors are here." One resident state he/she required assistance to the bathroom, the staff did not "always come" when the call light was used and that it took "a long time" for a staff response. Interview with certified nurse aide (CNA) #9 on 5/17/05 at 10:49 AM revealed when staff used the emergency lights to get assistance, such as when two people were required for mechanical lifts, staff waited "long periods of time..." to get assistance.	F 246	**F246 Quality of Life** A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This requirement will be met by: **A.** When any resident puts on his/her call light, staff will respond with in 3-5 minutes or with in 1-3 minutes for an emergency call light. **B.** We will in-service all staff at a general staff meeting that all call lights are to be answered promptly. **C.** The administrator and DON will in-service all staff on guidelines and timeliness of answering call lights promptly. This will be done at the general staff meeting. All staff members will be encouraged to respond to call lights and then to notify nursing staff to residents need. If a CNA answers a call light but needs assistance, after waiting 1-2 minutes, that CNA will go for assistance instructing the resident to turn on his/her call light if that CNA hasn't returned within one to two minutes. **D.** The DON will randomly monitor the length of time it takes staff to answer call lights. This will not be specific to day shift. The results of this call light monitoring will be presented at QI meetings.	6/14/05 6/14/05
F 272 SS=D	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI	F 272	**F272 Resident Assessment**	6/14/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah J. Wood — TITLE: Administrator — (X6) DATE: 6/10/05

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.

Reviewed w/ Ann Evenson ADON, Linda Hayward DON, & Lena Dawson DON in training on 6/14/05

accepted w/ changes pg. 3, 6, 8 & 11. 6/14/05

JR 6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 780, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272	Continued From page 1 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; 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 through the resident assessment protocols; and	F 272	A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the state. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; 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 through the resident assessment protocols; Documentation of participation in assessment. This requirement will be met as evidenced by: A. Resident #4 will have skin assessments done on a weekly basis. Skin assessments will be	

BR 6/14/05

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

PRINTED: 05/31/2005
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
	530017	A. BUILDING _____ B. WING _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 339 N BRIDGER AVE PINEDALE, WY 82941

(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 272	Continued From page 2 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure routine skin assessments for one of one (#4) sample residents who was determined by the facility to be at risk for developing pressure sores. Findings were: Medical record review revealed resident #4 had an annual Resident Assessment Instrument (RAI) dated 2/10/04, which documented that the resident was at risk for pressure ulcers secondary to immobility. The RAI also showed the resident's most recent pressure ulcer prior to the date of the RAI had healed in May, 2003. The resident's care plan, dated 2/11/04, identified interventions including "observe and report signs of skin breakdown/improvement." Nurses' notes dated 2/6/05 from 6 AM to 2 PM documented that the resident had developed a pressure ulcer on the right foot. This sore was described by a registered nurse (RN) as being a "...blackened area approximately the size of a 50-cent piece. Area is soft and mushy." Nurses' notes dated the next day, 2/7/05 from 6 AM to 2 PM, documented a "large area" on the right heel "approximately 50-cent size, area is black with red around outer area." Nursing documentation, dated 2/8/05, from 10 PM to 6 AM revealed a "right heel necrotic sore..." Physical therapy notes, dated 2/14/05 at 1:45 PM, described the ulcer as "black escher" and further described the debridement technique used. The care plan for this resident dated 2/11/04,	F 272	documented in the resident's records. B. All residents will have skin assessments done on bath days specific to the shift the bath is scheduled on. CNA's will be given a list of residents and when the skin assessment is due. They are to notify their charge nurse of bath and when it is time to perform the skin assessment by pulling the call light in the bath room. The charge nurse will perform the skin assessment C. Nursing staff will be in serviced on this new policy. Feed back from staff will be encouraged to find the best way of performing weekly skin assessments that would meet the needs of staff and the residents. D. The medical records clerk will audit charts bi-monthly to ensure nursing staff are documenting weekly skin assessments. She will report to the DON results of the chart. These results will be addressed at the quarterly QI meeting. Disciplinary action will be taken with any nurse not completing the weekly skin assessment.	

6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 272	Continued From page 3 which was in place at the time of the development of this wound, directed staff to observe and report the resident's skin condition. The monthly treatment sheets indicated the resident was to have weekly skin checks, which were to be documented with the initials of the nurse who performed the checks. The following concerns were noted regarding the lack of routine nursing skin assessments for this resident: The December, 2004, treatment sheet showed that skin checks were done twice: On 12/7/05 the comment sheet noted "pink" areas on the spine. On 12.14/04 the treatment comment sheet noted the resident had a healing rash. The January, 2005, treatment sheet lacked any weekly skin assessment documentation. A monthly nursing summary sheet dated 1/8/05 documented the resident's skin was dry and fragile. The director of nursing (DON) was interviewed on 5/18/05 at 7:01 PM. During the interview, the DON verified the lack of documentation or initials on the weekly treatment sheets and stated the reason for that was that the nurses documented by "exception."	F 272		
F 278 SS=D	483.20(g) - (h) RESIDENT ASSESSMENT 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. A registered nurse must sign and certify that the	F 278	**F278 Resident Assessment** The assessment must accurately reflect the resident's status.	6/14/05

gs 6/14/05

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

PRINTED: 06/31/2005
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
	536017	A. BUILDING _____ B. WING _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 756, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 278	Continued From page 4 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 Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or 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 medical record review and staff interview the facility failed to ensure two quarterly Minimum Data Set (MDS) assessments for two (#20, #4) of 10 sample residents were complete and accurate. Required signatures were missing and one pressure sore was inaccurately assessed. Findings were: Review of two quarterly MDS assessments for resident #20, one of which was dated 8/21/04 and the other dated 2/16/05, revealed section R2a on both forms was not signed. Interview with the MDS coordinator on 6/19/05 at 2:20 PM verified that the forms had not been signed. According to the December 2002, Centers for Medicare and Medicaid Services Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, section R2a is to be signed	F 278	A registered nurse must conduct or coordinate each assessment with the appropriate participation of the health professionals. 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 acouracy of that portion of the assessment. Under Medicare and Medicaid, and 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 1,000.00 for assessment; or causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than 5,000.00 for each assessment; Clinical disagreement does not constitute a material and false statement.	

DR 6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 700, 333 N BRIDGER AVE PINEDALE, WY 82941

(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 278	Continued From page 5 by the nurse coordinating the assessments. Completion of both signature and date is required. Review of the Resident Assessment Instrument (RAI), dated 2/7/05, for resident #4 revealed the resident had a stage II pressure sore. Review of nurses' notes, dated 2/6/05 and timed from 6 AM to 2 PM, revealed a licensed practical nurse's first documentation of the pressure sore on this resident's right foot. It was described by the nurse as a "...blackened area approximately the size of a 50-cent piece. Area is soft and mushy." Further review of the medical record revealed these additional documented observations of this wound: Nurses' note dated and timed 2/7/05, 6 AM to 2:30 PM: The wound was described as a large area on the right heel approximately the size of a 50-cent piece; the area was black and reddened around its perimeter. Nurses' note dated and timed 2/8/05, 10 PM to 6 AM: The wound was described as a right heel necrotic sore. Physical therapy notes dated and timed 2/14/05 at 1:45 PM: The wound was described as a "black eschar," which required debridement. Interview on 5/19/05 at 1031 AM with the licensed practical nurse who first documented the sore on 2/6/05 verified the area had been "black" in color and did not have fluid present. According to the Long Term Care RAI User's Manual, Version 2.0, if necrotic eschar is present, prohibiting accurate staging, the area should be staged as a stage IV until the eschar has been debrided.	F 278	This requirement will be met as evidenced by: A. We will obtain signatures on MDS dated 08/21/04 and 02/15/05 on resident #20. B. The DON will check all MDS's to ensure signatures have been obtained and to the accuracy of the information. C. A new pressure ulcer policy has been written and all nursing staff will be in serviced according to the pressure ulcer guidelines from the CMS manual system and the proper staging of pressure ulcers. D. The Medical Records Clerk will check the MDS for proper signatures prior to filing. The DON will randomly choose 4 MDS's per month to review for mistakes and will notify the MDS coordinator accordingly. This information will be reported at the quarterly QI meeting.	

The DON will Review the next MDS for Resident #4 to ensure proper Staging of pressure sores is documented on the assessment

6/14/05

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

PRINTED: 06/31/2005
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
	536017	A. BUILDING _____ B. WING _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 278	Continued From page 6	F 278		
	Interview with the director of nursing (DON) and the MDS coordinator on 5/19/05 at 8:21 AM revealed they believed the RAI of 2/7/05 was accurate because, in their opinion, the original description of the wound was inaccurate. During the interview they described the area as actually being a "blood blister," although neither person had documented that observation or their disagreement with the wound assessments.			
F 314 SS=G	483.25(c) QUALITY OF CARE 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, staff interview, and medical record review, the facility failed to ensure planned skin checks were carried out for one of one sample resident (#4) who was at risk for skin breakdown. This failure to follow the plan of care in order to prevent skin breakdown resulted in an avoidable pressure ulcer for this resident. Findings were: Observation of resident #4 on 5/17/05 at 9:19 AM revealed the resident wore a heel protector on the right foot. Interview with licensed practical nurse (LPN) #3 on 5/17/05 at 9:51 AM revealed the	F 314	**F314 Quality of Care** 6/14/05 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 will be met as evidenced by; A. Weekly skin assessment will be obtained on resident #4 as	

DR 6/14/05

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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 765, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7 resident had a history of a pressure sore on the right heel and had recently developed a new pressure sore to the right heel. The LPN was unsure of the cause for the current pressure sore. Review of the nurses' notes dated and timed: 2/6/05, 8AM to 2 PM, revealed the initial nursing documentation of the new pressure sore on the right heel. The pressure sore was described in this documentation as a "...blackened area approximately the size of a 50 [cent] piece." In addition, the documentation showed the area was "...soft and mushy." On 2/14/05 at 1:45 PM a physical therapy note revealed the sore consisted of "black eschar." The note further described the debridement technique used to remove the damaged tissue. The resident's annual Resident Assessment Instrument (RAI) dated 2/10/04 documented that the resident triggered for pressure sores, was at risk secondary to immobility, and that the resident's last pressure sore had healed in May 2003. The resident's plan of care (dated 2/11/04) developed subsequent to this assessment documented interventions including "observe and report signs of skin breakdown/improvement." Review of the treatment sheet for December 2004 revealed nursing staff were to carry out and document "weekly" skin checks. The following concerns were noted related to the lack of timely nursing skin assessments: Review of the treatment sheets for December 2004 and January 2005, immediately prior to the February discovery of the new pressure sore, revealed two skin checks by nursing staff were done in December and none in January.	F 314	per resident's care plan and physician's orders. The CNA's who are assigned to get resident #4 up will be expected to perform a head to toe skin assessment and report any signs of changes to the charge nurse who then will perform a more thorough skin assessment. If there are any indications of compromise to the skin, interventions will be put into place. All resident will receive a weekly skin assessment. B. Skin assessments are to be performed by a charge nurse to residents on admission and quarterly there after to determine if they are at risk. Those residents found to be at risk for skin breakdown will be identified by a symbol placed on the door of their room. This will alert nursing staff to do a thorough skin assessment daily and to report any abnormal finding to the charge nurse. C. All staff will be in serviced on CMS guidelines for prevention, assessment, and intervention for pressure	

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

PRINTED: 06/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 According to the December 2004 treatment sheet, on 12/7/04 an area of concern was noted on the resident's spine and on 12/15/04 a healing rash was noted. A monthly nursing summary, dated 1/8/05, was the only nursing documentation found related to the resident's skin condition for the month of January 2005. The documentation revealed the resident's skin at that time was "dry and fragile." Interview on 5/18/05 at 7:01 PM with the director of nursing (DON) revealed the documentation was not done because nurses charted by "exception." The DON verified that the treatment sheets for December 2004 and January 2005 did not show who performed the skin assessments or when they were performed, although all other treatments on the same sheets were documented. Further review of the nursing notes with the DON failed to reveal any weekly skin assessment documentation. Clinical practice guidelines in order to maintain and improve tissue tolerance to pressure and to prevent injury recommend all individuals who have been determined to be at risk should have a systematic skin inspection at least once a day, paying particular attention to the bony prominences. Results of skin inspection should be documented. Skin inspection provides the information essential for designing interventions to reduce risk and for evaluating the outcomes of those interventions. (The National Pressure Ulcer Advisory Panel's Summary of the AHCPR Clinical Practice Guideline, Pressure Ulcers in Adults: Prediction and Prevention [AHCPR Publication No. 92-0047, Rockville, MD: May 1992]). Prevention is the most important factor in managing pressure sores. Identifying risk factors	F 314	ulcers. All nurses will be held responsible for documenting their weekly skin assessments. Charts will be audited bi-monthly by the medical records clerk who will report to the DON. Those nurses who are not completing their assessments will be dealt with accordingly. D. The DON will review this information and present it at the quarterly QI meetings.	

6/2 6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 and examining the patient's skin, especially over bony prominences, at least daily, are essential for preventing pressure sores. (Beers and Berkow, eds., The Merck Manual of Geriatrics, 3rd ed. [Merck Research Laboratories, Merck & Co., 2000]).	F 314		
F 324 SS=K	483.25(h)(2) QUALITY OF CARE The facility must ensure that 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 review of facility documentation, including medical records, the facility failed to provide continuous nursing supervision of resident care areas. Nursing units were left unsupervised while all staff attended a mandatory meeting on 5/4/05. The facility census at that time was 34. During the meeting one (#37) of six sample residents who had been assessed as at risk for elopement, exited the facility, fell, and fractured his/her arm. The facility had also assessed five other residents (#2, #12, #26, #28, #35) as being at risk for elopement from the facility. After this incident, the facility failed to thoroughly investigate the cause of the elopement or take action to prevent further such incidents to residents in the future, resulting in immediate jeopardy. At the time of the survey, the facility's census was 37. Findings were: Observation during the initial tour on 5/16/05 at 4:21 PM revealed resident #37 was wandering. The resident was observed as she exited the facility through the west hall door. An alarm	F 324	**F 324 Quality of Care** 6/14/05 6/14/05 The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This requirement will be met as evidenced by: A. During any mandatory meeting, nursing staff scheduled to work the floor will be excused. All meetings that require attendance of the nursing staff will begin with a role call of those staff members excused and responsible for supervision of the nursing units. The mandatory meetings will be video taped so those staff who missed the meeting will be able watch the meeting at a	

#2 6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 336 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 324	Continued From page 10 sounded, which alerted staff, who then immediately responded and brought the resident back into the building. The resident was then redirected back to his/her room. Interview on 5/17/05 at 2:28 PM with two certified nurse aides (CNAs #10 and #17) revealed three doors alarmed if any residents left the facility, and Wanderguard devices also alarmed if residents wearing Wanderguards attempted to leave the building. Interview with the CNAs also revealed that the only way to reset a Wanderguard when it was alarming was to key in a specific code. Medical record review for resident #37 revealed a face sheet, dated 8/3/04, which documented the resident had lived at the facility since December 2002 and had diagnoses including osteoporosis (a condition in which calcium loss affects the bones, placing a person at higher risk for fractures) and Alzheimer's disease. The resident's most recent quarterly Minimum Data Set (MDS) assessment, dated 3/9/05, assessed the resident's cognition as "moderately" impaired, with the resident requiring cues and supervision. Documentation on the MDS revealed the resident had wandering behavior symptoms with no rational purpose, and was seemingly oblivious to personal needs or safety. The facility coded the behavior as both occurring daily and not easily altered. An elopement risk assessment, dated 3/9/05, identified the resident was at risk for falls. Social services' progress notes, dated 3/8/05, documented the resident's wandering behavior and agitation had increased. Social services' notes on 3/11/05 revealed the resident was agitated, wandering, and "...had been able to get outside and [was] found tapping on administration assistance [sic] window." The social services director further documented that a warm blanket	F 324	later date, and will sign off that they have seen the video as to ensure they receive their training as well. Staff will have two weeks to view the video tape. B. All residents will be assessed upon admission and quarterly for risk of wandering and elopement. Those found to be at risk will have a wander guard applied to their ankle or wrist. C. Wander guard transmitters and receptors will be tested weekly as part of regularly scheduled testing. Maintenance staff will test the wander guard door receptors and document the results. Nursing staff will test the patient transmitters and document results. 1. If the Wander guard system does not sound when a patient exits, door receptors and resident transmitters will be tested on a daily basis for 30 days. Wander guard alarm	

Residents #37, 2, 12, 24, 28 + 35 have all had their wanderguards tested daily for 30 days to ensure they are functioning properly.

YR 6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 324	Continued From page 11 was placed on the resident after the resident was brought back into the building. A monthly summary sheet (a nursing document), dated 3/28/05, revealed the resident wandered and, therefore, utilized a Wanderguard bracelet. Nurses' notes dated 5/4/05 at 3:15 PM revealed an employee found the resident lying on the ground in the garden area. According to the documentation, the resident stated to the employee that he/she had left, upper arm pain. Nurses' notes from 5/4/05 at 4:30 PM documented that x-rays taken at the local medical clinic revealed the resident had sustained a left humeral head fracture. Interview with the occupational therapist (OT) on 5/17/05 at 2:54 PM revealed she was the first employee to find the resident. The OT stated she had assisted another resident back to room #207 when she heard crying, looked toward the nurses' desk and saw no residents in the corridor or at the desk. The OT stated she then looked out the window and saw resident #37 lying on the ground outside. Interview on 5/15/05 at 1:01 PM with the licensed practical nurse (LPN #5) revealed she had worked the day shift on 5/4/05. The LPN stated she was at a meeting when an off-duty CNA motioned for her to leave the meeting and informed her that resident #37 had fallen. The interview revealed LPN #5 did not know how the resident exited the building and did not know if the resident's Wanderguard or the door alarm had been ringing. Interview on 5/17/05 at 3:17 PM with CNAs #3 and #17 revealed both worked the evening shift on 5/4/05 and both had attended the mandatory staff meeting. When asked who had	F 324	codes will only be distributed to staff members. Signs have been posted at the doors to instruct staff not to silence the alarm until the source of the signal has been determined. 2. Policy training will be done for all staff upon hire, orientation, and annually with emphasis on a facility-wide responsibility. 3. Codes to the alarms will be changed annually by maintenance. D. The DON or ADON will ensure that staff remains on the floor during staff meetings and the charge nurse will assign a CNA or EA to remain on the floor during meals. The DON, ADON or other appointed managers will perform random spot checks to ensure the floor is covered. These results will be	

SR 6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 788, 333 N BRIDGER AVE PINEDALE, WY 82941

(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 324	Continued From page 12 been assigned to the floor during the meeting, both stated, "No one." Interview of 6/17/05 at 3:33 PM with a registered nurse (RN) revealed she was the social services director and had investigated the incident. The RN verified that no staff had been assigned to supervise the nursing units while the meeting occurred. The RN also stated that she believed the resident was able to exit the building, unobserved, on 5/4/05, because no staff members were assigned to the nursing units during the mandatory staff meeting. Further interview revealed the investigation at the time of the incident did not identify whether or not the Wanderguard had actually alarmed or whether the Wanderguard was functional. The RN indicated that although she was aware that an alarming Wanderguard required a manual reset, she had not determined from any staff during the course of her investigation whether or not anyone had, in fact, reset the resident's Wanderguard. This RN further stated that follow-up action consisted of in-servicing one staff member. The RN stated the nurse who was in-serviced had never actually worked on a staff meeting day and did not know she was expected to assign staff to supervise the units during mandatory meetings. According to this interview, the nurse who had been in-serviced thought the "day shift" nurse had been responsible for staffing during that meeting. This interview also revealed that no other staff persons had been in-serviced regarding this situation. This fact was verified by interview with the DON and the administrator on 5/17/05 at 4:01 PM. Another interview with the DON and the administrator on 6/17/05 at 5:25 PM revealed five	F 324	presented at quarterly QI meetings.	

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 758, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 324	Continued From page 13 other residents (#2, #12, #26, #29 and #35) were also elopement risks and wore Wanderguards to alert staff if any one of them attempted to leave the building. Interview with the maintenance director on 5/18/05 at 7:30 AM revealed that prior to the incident there had not been any routine, documented preventive maintenance testing of the door security systems, including the Wanderguard system. Furthermore, the interview revealed that no system testing had been implemented following the incident involving resident #37's elopement and subsequent injury Based on the survey team's findings, at 4:15 PM on 5/17/05, the administrator and the DON were informed the facility had not fully investigated or attempted to identify the causative or contributing factors related to the elopement and injury of resident #37 had the facility implemented actions to prevent future lack of supervision for resident #37 and all other residents during mandatory staff meetings. At that time the facility was notified that immediate jeopardy existed. On 5/18/05 at 1700 the immediate jeopardy was abated by the following actions; (Policy Action): During any mandatory meeting, nursing staff scheduled to work the floor will be excused. All meetings that require attendance of the nursing staff will begin with a roll call of those staff members excused and responsible for supervision of the nursing units. Documentation provided by the administrator on 5/18/05 at 5:00 PM revealed staff in attendance at the meeting on 5/18/05 and a roll call of staff supervising the floor. (Policy Action): Maintenance staff will test the	F 324		

SP 6/14/05

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

PRINTED: 05/31/2005
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 _____	05/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBLETTE CENTER	PO 769, 333 N BRIDGER AVE PINEDALE, WY 82941

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 324	Continued From page 14 Wanderguard door receptors weekly and document the results. If the Wanderguard system does not sound, door receptors and resident transmitters will be tested on a daily basis for 30 days. Observation on 5/18/05 at 1050 AM revealed maintenance was testing door receptors and nursing was checking resident transmitters. C. (Policy Action): Wanderguard alarm codes will only be distributed to staff members. Signs posted at doors will instruct staff not to silence the alarm until the source of the signal has been determined. (Policy action): Policy training will be done upon hire, orientation, and annually. In-service education of the new policy was done on 5/18/05. The in-service was videotaped by the facility to ensure all staff would receive the new policy information.	F 324		