Reviewed & approved after discussion, telephone on 6/1/07 @ 3:30 pm with JoAnn Faust ADON acting DON, and changes made on pages 16, 30, 53 & 54

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
	535043	A. BUILDING ______ B. WING ______	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

RECEIVED MAY 15 2007 Wyoming Dept of Health Licensing and Surveys

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff notified the physician regarding a change in condition in a timely manner for 2 (#62, #68) of 4 sample	F 157	**F157 Notification of Changes** The Facility will assure that staff notifies the physician in a timely manner regarding changes in condition. Resident # 68's physician has been notified of his/her condition. Resident # 62's physician has been notified of his/her condition. A chart review of residents will be completed to assure that no other residents have had changes in condition that were not reported timely to their physicians. The Director of Nursing will review the 24-hour reports and the CNA report sheets on a daily basis. Any changes of condition will be reviewed to assure that proper physician notification has occurred. CNAs and Nurses will be in-serviced on or before May 22 to review their responsibilities regarding reporting and/or physician notification. The DON will track the notification process and write a report for the QA committee with the results monthly for the next 3 months and then quarterly thereafter. The Director of Nursing is overall responsible.	5/31/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ron Nel... TITLE: Administrator (X6) DATE: 5-10-07

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.

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F 157	Continued From page 1 residents who had a change in condition. The findings were: 1. Review of the 3/28/07 interdisciplinary progress notes for resident #68 revealed "L [left] top of foot has sore/ulcer noted, soft edema noted thus unable to palpate pulse...." "L [left] leg with splint seems not in alignment..." Continued review of the interdisciplinary progress notes revealed the next note in regard to the newly identified pressure ulcer was on 4/4/07 at 5 PM by nursing which was "Noted open areas on top of foot - scabbed. Area is very puffy with soft edema and a faint purple color. Will see about appt [appointment] with orthopedist to have this evaluated." Review of the entire medical record revealed the physician was not notified of the pressure ulcers from the first entry on 3/28/07 until the entry on 4/4/07 (7 days) later. Interview with the director of nursing on 4/18/07 at 9 AM confirmed there was no evidence the physician was called prior to the seventh day after initial identification of the ulcer. Review of the 2/7/07 3:10 AM nursing notes for resident #68 revealed the resident had more pain than usual and did not sleep at all. Further review revealed the resident was "begging for pain medicine." Review of the 2/8/07 11 PM nursing notes revealed the resident was using the call light frequently and was yelling out "help". Review of the 2/8/07 midnight nursing notes revealed the resident almost continually yelling out "help", was very confused and did not recognize the nurses, and was groggy to the extent that staff had to "Literally had to help ... [him/her] with ...[him/her] water." "...[s/he] was trying at 1st to suck water from an empty cup then was trying to drink from ...[him.her] other cup upside down with the water dripping on ...	F 157		

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F 157	Continued From page 2	F 157		

[him/her]." Review of the 2/12/07 5 AM nursing notes revealed the resident had increased left lower extremity pain; was administered 2 percocet (pain med), 1 Oxycontin (pain med) and Ambien (hypnotic for sleep) without pain relief or being able to sleep. Continued review revealed the resident used the call light every five to ten minutes and had increased confusion. Review of the 3/7/07 3 AM nursing notes revealed the resident used the call light every five to ten minutes, was given 3 pain medications and a sleeping pill but did not sleep, was unable to be re-directed, and was not comprehending what staff told him/her. Review of the entire medical record revealed no evidence the physician was notified of the resident's change in mental status.

2. Review of the 3/22/07 physician's progress notes for resident #62 revealed his/her blood pressure (B/P) was higher than it had been. Further review revealed the physician added Lisinopril (for hypertension) 10 milligrams (mg) to the resident's medication regimen. Continued review revealed the physician requested daily monitoring of the resident's B/P for two weeks to determine the effectiveness of the Lisinopril. Review of the 3/22/07 physician's telephone order revealed an order to check the resident's B/P daily for two weeks and send the results by facsimile (fax) to the physician at the end of the two week period. Review of the medical record and Medication Administration Records (MARs) for March and April 2007 revealed the resident's B/P was taken on 3/23 through 3/26/07 (4 days), was not taken on 3/26 or 3/27/07, and was again taken on 3/29 through 3/31/07 (3 days). There was no evidence the resident's B/P was again checked until 4/14/07 (14 days later). Review of the entire medical record revealed there was no

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F 157	Continued From page 3 evidence the results of the B/P checks that were done were faxed to the physician. Interview with the DON on 4/19/07 at 1:00 PM confirmed the results were not faxed to the physician.	F 157		
F 161 SS=E	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on facility documentation and staff interview, the facility failed to assure all resident funds were protected by a surety bond. The findings were: Interview with the business office manager on 4/17/07 at 2:30 PM revealed the resident trust fund account was insured by a $15,000 surety bond. Review of facility documentation revealed there was $16,181.68 deposited in the resident trust fund account as of 3/31/07. Interview with the business office manager confirmed the surety bond did not cover the total amount of trust funds in the resident's account.	F 161	**F161 Assurance of Financial Security** The Facility will purchase a surety bond to assure the security of all personal funds of residents deposited with the facility. A new surety was received on 4/23/07 in the amount of $20,000.00. At the end of each month when resident funds are reconciled a log will be completed. The log will indicate the amount of the trust fund and the amount of the surety bond. Whenever the amount of the trust accounts starts to get close to the amount of the bond a new bond will be purchased. The Business Office Manager will review the log monthly and report any irregularities to the QA Committee. The BOM is responsible for overall compliance.	5/7/07
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by:	F 166		

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F 166	Continued From page 4 Based on family interview, staff interview, medical record review, job description review, and review of facility procedures, the facility failed to ensure efforts to resolve grievances for one (#40) of one sample resident who voiced grievances. The findings were: Interview on 4/17/07 at 5:41 PM with a family member for resident #40 revealed the family had voiced concerns "a number of times" related to care issues, cleanliness of the resident's environment, and food issues. The family member voiced frustration related to lack of the facility's response and stated the facility had not acknowledged whether a solution or resolution was obtained. Review of the resident's medical record showed no documentation related to the family voicing concerns. Social service notes documented quarterly that the family was actively involved in the resident's care. Yet, there was no acknowledgment of social service involvement with the family related to grievances and/or their resolution. Interview with the director of social services on 4/19/07 at 10:05 AM revealed she was aware of family dynamics, issues, and the multiple concerns regarding care for resident #40 and environmental concerns. During the interview the social worker stated she was not involved with the family or their concerns voiced since the issues were not "behavioral" and she did not handle these other grievances. The social worker further stated her responsibility with grievances was to collect the resolution report if a department head formally documented a grievance resolution. Further interview revealed concerns/grievance resolutions were usually verbal. The social worker stated she did not log	F 166	**F166 Grievances** The Facility will make prompt efforts to resolve all grievances including those with respect to other resident behavior. The Social Service Director will interview the family of resident #40 to document grievances and concerns. The Social Service Director will then investigate these issues and work toward resolution with the family and resident. The SSD will meet with interviewable residents in a resident council format to identify other grievance issues that have not been addressed. The SSD will document and log all resident and family grievances and concerns through resolution or stalemate. Grievance forms will be given to appropriate departments for investigation and the SSD will follow up with the family or resident. The Administrator will review the log at least weekly and initiate corrective actions as necessary. The Social Service Director will provide a written report to the QA Committee regarding the number of grievances per month and how many were resolved. The Social Service Director is responsible for overall compliance.	5/31/07

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F 166	Continued From page 5 grievances or decisions made. Review of the facility's grievance/concern process titled, "The Facility's Complaint Procedure," revealed that after a verbal or written complaint was submitted, the issue would be investigated and the resident would be informed related to the decision or action taken. Review of the job description for the director of social services (effective date: 9/1/04) revealed essential functions and responsibilities included: "...Review departmental complaints and grievances from residents/families etc. and provide reports to the administrator indicating what action(s) were taken to resolve the complaint....[and] Provides advocacy services to residents...."	F 166		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the least restrictive methods was utilized for two (#2, #82) of three sample residents who required restraints. The findings were: 1. Periodic observations from 4/16/07 at 2 PM through 4/19/07 at 11 AM revealed resident #82 utilized an enclosed framed wheeled walker (merry walker) at times. Observation and attempted interview with the resident on 4/18/07 at 2 PM revealed the resident was unable to open the front gate and exit the device. Interview	F 221	**F221 Physical Restraints** The Facility does assure that all residents are free of physical restraints imposed for the purposes of discipline, convenience, and that are not required to treat the resident's condition. Resident # 82 has had an assessment completed for the use of the "merry walker". This device continues to be appropriate for this resident. Resident # 2 was assessed by Physical Therapy for the use of the safety belt while in the wheel chair. Without the safety belt resident #2 often fell out of the chair and onto his face due to leaning forward. He/she has had no further falls since implementation of the safety belt.	

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F 221	Continued From page 6 with registered nurse (RN) #10 on 4/18/07 at 2:10 PM confirmed the resident was unable to open the gate and exit the device. The following concerns with restraint utilization were identified: a. Review of the medical record revealed the most current restraint assessment was completed on 9/6/05 (1 year 7 months ago). Review of that assessment revealed the medical symptom that led to the consideration of the use of restraints was identified as "organic brain syndrome." b. Review of the 3/8/07 care plan revealed the following: "Extensive assist with 1 for ....ambulating. Limited with 1 for locomotion short distances. Staff assists to meals. Res. [resident] will walk with assist of 1 if staff puts their hands out for ... [the resident] to hold onto." "Staff must take to locations." Continued review of the care plan revealed the utilization of the merry walker as a restraint was not addressed. Use of the merry walker was identified only as a goal and a strength under the "Impaired physical mobility" problem and as a means for ambulation under the problem "Potential for falls." c. Review of the medical record revealed no evidence an evaluation of the effectiveness of the restraint had been performed since 9/6/05. There was no evidence elimination or reduction of restraint utilization had been considered since 9/6/05. Finally, there was no evidence that less restrictive measures had been considered or attempted since 9/6/05. 2. Observation on 4/17/07 at 9:52 AM revealed resident #2 was seated in a wheelchair wearing a lap belt. At the time, the resident requested the surveyor remove the belt. A staff member nearby heard the request, and upon talking with the resident, found the resident's right fingers had	F 221	A review of residents will be conducted to identify any other residents that may be affected. All residents that utilize devices will be assessed to determine if the device used is appropriate and is the least restrictive. The Facility will assess all residents that use devices on admission, on change of condition, and at least quarterly. The Care Plan Team will review the chart prior to care conference to assure that all assessments have been completed. The DON will monitor the use of devices and compile a report for the QA Committee monthly for the next 3 months and then quarterly to assure compliance. The Director of Nursing is responsible for overall compliance. Date certain May 31st.	5/31/07

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F 221	Continued From page 7 become entangled in the belt. On 4/18/07 at 1:25 PM, interview with the director of nursing (DON) revealed the resident was capable of releasing the lap belt, which was used as a positioning device. The following concerns were found related to the use of the lap belt: a. Observation and interview with the resident on 4/18/07 at 2:42 PM revealed s/he was not as alert as the previous morning, and was not able to release the belt, when asked to do so. b. The residents most recent quarterly Minimum Data Set assessment dated 1/29/07 revealed that at the time of the assessment, the resident had both short term and long term memory problems, had moderately impaired cognition, and required extensive to total assistance with bed mobility and transfer. The assessment documented at that time, ambulation did not occur during the assessment period and the resident had not utilized a restraint. Further record review, failed toshowan assessment for the lap belt had been completed. A second interview and medical record review with the DON on 4/19/07 at 9:01 AM revealed she was unable to find any assessment for the lap belt or documentation related to the resident's ability to release the belt.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		

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F 225	Continued From page 8 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of policies and procedures, and review of facility completed internal investigations, the facility failed to immediately report an allegation of misappropriation of resident funds. The findings were: Review of the facility investigation of missing	F 225	**F225 Staff Treatment of Residents** The Facility will assure that all allegations of abuse are reported appropriately. Resident #81 has had the alleged theft of her money investigated. The Social Service Director will meet with interviewable residents in a resident council format to identify any other residents that may have been affected. The SSD will take what ever action is needed. All staff will be in-serviced on May 14th regarding the expectation that the Administrator is to be notified immediately regarding any allegations of abuse, neglect or misappropriation of resident property or funds. The Administrator will then delegate responsibilities appropriately so that investigations are completed within the time line. The Social Service Director will document all allegations of abuse and create a report for the QA Committee. This report will be presented at the committee meeting monthly. The Administrator is responsible for overall compliance.	5/31/07

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F 225	Continued From page 9 resident funds revealed non sample resident #81 was admitted on 4/12/07. The following morning (4/13/07), the resident discovered $83.00 missing from his/her dresser drawer and notified registered nurse (RN) #1. Interview with the facility social services director (SSD) on 4/19/07 at 9 AM revealed the nurse placed a hand written note in the SSD's facility internal mail box which stated "resident missing $83.00, please follow up." The SSD stated she was on vacation from 4/12/07 through 4/17/07 and did not see the note until 4/17/07. Review of facility abuse policy and procedures, section 3.4, paragraph 2 instructs: "All...allegations of ...misappropriation of property will be reported immediately to the Administrator." In addition, review of the facility abuse investigation checklist dated 4/18/07 revealed the administrator or director of nursing must be notified immediately but was not checked as having been done.	F 225		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facility abuse policy, the facility suspected abuse reporting tool, and staff interview, the facility failed to report one of one allegations of misappropriation of resident property to the survey and certification agency and other officials in accordance with the facility policy. The findings were:	F 226	**F226 Staff Treatment of Residents** The Facility will assure that all allegations of abuse are reported appropriately to the survey and certification agency and other officials in accordance with facility policy. Resident #81 has had the alleged theft of her money investigated. The Social Service Director will meet with interviewable residents in a resident council format to identify any other residents that may have been affected. The SSD will take what ever action is needed. All staff will be in-serviced on May 14th regarding the expectation that the Administrator is to be notified immediately regarding any allegations of abuse, neglect or misappropriation of resident property or funds. The Administrator will then delegate	

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F 226	Continued From page 10 Review of the facility investigation of missing resident funds revealed non sample resident #81 was admitted on 4/12/07. The following morning (4/13/07), the resident discovered $83.00 missing from his/her dresser drawer and notified registered nurse (RN) #1. Interview with the facility social services director (SSD) on 4/19/07 at 9 AM revealed the nurse placed a hand written note in the SSD's facility internal mail box which stated "resident missing $83.00, please follow up." The SSD stated she was on vacation from 4/12/07 through 4/17/07 and did not see the note until 4/17/07. Review of facility abuse policy and procedures, section 3.5, paragraph 1 instructs: "the facility will conduct and complete an internal investigation within 48 hours and report credible suspicion an/or allegations to the appropriate state enforcement/regulatory agency within 24 hours." The facility did not report the incident to the Office of Healthcare Licensing and Surveys until 4/17/07.	F 226	responsibilities appropriately so that reports to appropriate agencies could be accomplished timely and investigations are completed within the time line. The Social Service Director will document all allegations of abuse and create a report for the QA Committee. This report will be presented at the committee meeting monthly. The Administrator is responsible for overall compliance.	5/31/07
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of facility documents, the facility failed to ensure residents were treated with dignity and respect during two of three dining observations. In addition, the facility did not	F 241		

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F 241	Continued From page 11 ensure staff knocked prior to entering resident rooms during two of six observations of medication pass. The findings were: In regard to dining: 1. The following concerns were found related to dignity during the dining process and dignity with dining service: Interview with restorative certified nurse aide (RCNA) #2 on 4/16/07 at 4:04 PM revealed there were two seating times for dining service during the evening meal; the first of which started at 4:30 PM and the second at approximately 5:15 PM. The RCNA stated dependent and assisted residents were assigned dining times, but independent residents dined whenever they chose. Observation of the independent dining room on 4/16/07 from 4:30 PM till 5:50 PM when the observation ended revealed residents were not served on a 'first come' basis and although table mates were seated together at the same time, not all table mates were served at the same time. For example, the observation revealed residents #32, #42, #39, and #81 were seated at table 6 at 4:30 PM. Resident #32 received the first tray which was an alternate choice and which was passed at 4:52 PM, 22 minutes after service should have started. The resident finished eating at 5:04 PM before any of the table mates had been served. At 5:07 PM resident #54 arrived and sat at table #7. This resident received the scheduled meal choice at 5:10 PM. The other three residents at table 6 still had not been served. Table 6 resident #39 received the scheduled meal at 5:13 PM. Resident #81 was served the scheduled meal at 5:18 PM and, the last table 6 resident served, resident #42,	F 241	**F241 Dignity** The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents #32, #42, #39, #81, #31, #54, #82, #2, #40, #46, #79 and #80 will be served meals timely once seated in the dining room. Residents #45 and #50 will not be seated in the dining area prior to meal time. Residents #73 and #77 will have their privacy respected by having the staff knocks on their doors prior to entering. A tray card system will be implemented in the dining room that will limit the amount of time a resident will wait before receiving meal service. The staff will write down the resident's choice on the meal card and place it upside down on the stack. When dietary retrieves the meal cards, they will turn them over. Any new cards provided to dietary staff will be placed on the bottom of the stack. This method should assure a "first come, first serve" system. Dining room #2 residents will not be placed in the dependent dining area prior to the meal. All staff will be in-serviced on or before May 15th related to dignity issues, including knocking on doors and dependent dining area issues, and the meal tray card system.	

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F 241	Continued From page 12 received his/her meal choice at 5:19 PM (49 minutes after seated and waiting). Other observations during the evening meal service revealed the first three trays served went to residents at three separate tables, number 6, number 4, and table 14. At 4:58 PM, twenty-eight minutes after the posted time for meal service, only three residents had trays while approximately 25 other residents in the room watched those residents eat. The observation revealed tray line was interrupted while tray service to the assisted dining area was done. Tray service to the assisted dining area restarted at 5:04 PM. Interview with residents #39 and #81 on 4/16/07 at 5:22 PM revealed table mates were "often" not served at the same time even though they were seated at the same time. Both stated they did not like having to wait so long and watch table mates eat. Interview with the dietary manager on 4/16/07 at 5:32 PM revealed the open dining started in January and usually ran "smoother." When asked why most of the assisted dining residents were seated at 4:30 PM, rather than their assigned time, the manager stated the two seating times for the assisted residents were done to make it easier for the nursing staff to get everyone up. A second observation of service in the independent dining area on 4/17/07 from 4:32 PM till 5:17 PM revealed issues related to service. Resident #80 was seated at 4:32 PM along with six other residents. Yet, when resident #80 received his/her tray at 4:56 PM, eight other residents, #82, #2, #40, #42, #32, #46, #31, and #79, all whom entered after resident #80, were served before resident #80. 2. Observation in the assisted dining room on	F 241	Random audits will be done by dietary to assure that residents will be treated in a dignified and respectful way during meal service and nursing staff to assure that staff continues to knock at resident doors. Results of these audits will be reported to the DON who will evaluate them and disciplne and/or in-service as appropriate. The DON will also compile a report regarding the audit results for the QA Committee monthly for the next 3 months and then quarterly. The DON has overall responsibility.	5/31/07

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F 241	Continued From page 13 4/16/07 from 4:30 PM until 6 PM revealed the following concerns with dignity: a. Observation revealed residents #45 and #50 were seated at the table in the dining room at 4:30 PM. Continued observations revealed both residents sat at the table with their eyes closed and heads slumped until trays were served at 5:40 PM (1 hour 10 minutes later). Observation revealed neither resident was offered fluids during that time. Review of the "Culture Change/Serving Time for the Dining Room" chart revealed both residents were scheduled for second seating at 5:15 PM. At 5:45 PM, when the surveyor asked certified nurse aide (CNA) #13 why the residents were seated in the dining room so early, the CNA said she did not know. In regard to knocking: 1. Observation on 4/16/07 at 4:03 PM revealed registered nurse (RN) #1 entered the room of resident #73 without knocking. 2. Observation on 4/16/07 at 4:08 PM revealed RN #1 entered the room of resident #77 without knocking. 3. During an interview with RN #1 at 4:20 PM, she stated she knew she had forgotten to knock prior to entering two residents rooms but that she usually remembers to do so.	F 241		
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS 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.	F 246		

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F 246	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff accommodated the special laundry needs for one (#79) of one sample residents whose laundry required washing without bleach. The findings were: 1. Review of the 3/07 physician's orders for resident #79 revealed s/he had bleach listed as an allergy. Further review revealed instructions to launder the resident's clothing and linen separately and without bleach. Review of the 2/6/07 care plan revealed a problem identified as "Potential for eczema type rash R/T [related to] allergies to bleach & chocolate." However, interview with certified nurse aide (CNA) # 28 on 4/19/07 at 10:35 AM revealed he obtained and utilized linens from the regular linen closet for this resident; he stated he was unaware the resident had an allergy to bleach. Observation of the resident's legs during perineal care on 4/17/07 at 9:10 AM revealed there was a rash on his/her legs; the resident was scratching the rash at the time of the observation. Interview with the laundry aide on 4/19/07 at 10:45 AM revealed all linen and clothing were washed with bleach and that she was did not do this resident's laundry separate from other residents' laundry. She further stated she was unaware the resident had an allergy to bleach.	F 246	**F246 Accommodation of Needs** The Facility will assure that residents will be given reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Resident #79 will have his/her clothing laundered appropriately. All residents will be evaluated for accommodation of special needs. Any resident identified with a special need will have that need evaluated and a plan of care developed to accommodate it if it is safe. The Social Service Director will keep record of special needs accommodation and prepare a report for the QA Committee on a monthly basis for the next 3 months and then quarterly. The Social Service Director is responsible for overall compliance.	5/31/07
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests	F 248		

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F 248	Continued From page 15 and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, family interview, and medical record review, the facility failed to ensure staff provided activities to meet the individual needs of nine (#2, #12, #25, #62, #63, #68, #79, #80 , #82) of 14 sample residents and one (#49) non sample resident. The findings were: 1. Observation on 4/17/07 at 9:52 AM of resident #2 revealed s/he wondered the nursing station 1 hall, and spent time sitting in the lobby and watching staff work. Review of the resident's activity care plan, revised on 1/23/07, revealed the resident enjoyed music programs, exercise, and visitor interaction. Yet, at the time of the observation, an exercise activity was occurring which s/he did not attend. Interview with the activity director on 4/18/07 at 10:43 AM revealed the resident did not stay in activities unless the spouse was at the facility and attended. Further interview revealed there were no goals developed with regard to the number of group activities the resident would attend and/or whether a one to one activity program should be supplemented or implemented. 2. Random observations of resident #12 on 4/17/07 from 7:46 AM until the resident went into the dining room at 11 AM revealed the resident spent the morning wandering. The observation also revealed the resident was invited to the exercise activity, but refused. Review of the activity progress notes dated 1/4/07 revealed the	F 248	**F248 Activities** The Facility will provide for an ongoing program of activities designed to meet, in accordance of the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. Resident #2 has been discharged to a more appropriate setting. Resident #12 will be assessed and appropriate activities will be implemented. Residents #25, #80, #79, #68, #55, #62, #66, #73 and #63 will have their assessments reviewed. Their one-to-one programs will have goals documentation to show progress to those goals. Resident #49 will be reassessed and an activity program developed to meet his/her individuality. An audit will be completed to determine if there are other residents that would benefit from one-to-one activity programs. Residents that have this need will be care planned with specific goals and interventions. The Activity Consultant will review the care plans and make necessary adjustments. The Activity Director will prepare a report regarding the activity assessments and one-to-one program for the QA Committee monthly for the next 3 months and then quarterly. The Activity Consultant has overall responsibility. including resident #82 added per request of Nurse Supervisor via telephone on 6/5/07 @ 3:55pm Sandra Peterson RN	5/31/07

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F 248	Continued From page 16 resident was both physically and verbally abusive and did not enjoy group activities. Activity progress notes dated 4/6/07 restated the previous annotation, but this note included that the resident enjoyed reading the newspaper and mail and "...enjoys wondering the halls." Interview with the activity director on 4/18/07 at 10:43 AM revealed the resident would not stay in an activity even when escorted. When asked, she stated she had not considered the resident as a possible candidate for one to one activities. 3. Review of the activity care plan for resident #25 revealed s/he received activities three times a week as a one to one. Interview with the activity director on 4/18/07 at 10:43 AM revealed the resident was on a one to one program. Further interview revealed no goals or responses were documented during the one to one visits. Activity staff documented the visit occurred. The activity director identified five other residents, #55, #62, #66, #73, and #63 as receiving the one to one program. The activity director stated the purpose was "just to visit." 4. Random observations of non-sample resident #49 on 4/17/06 from 9:27 AM to 10:45 AM, when the resident was seen napping in his/her wheelchair, revealed the resident wondered the facility. Review of the medical record revealed activity notes dated 2/1/07 which documented the resident "comes in and out of activities" and could become aggressive and angry when redirected. The note further cautioned the resident used inappropriate touch when around female staff. Review of the resident's plan of care revealed the resident's goal was to remain active in his/her wandering and socialization with staff and visitors. When interviewed on 4/18/07 at	F 248		

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F 248	Continued From page 17 10:43 AM, the activity director stated she had not considered planning a one to one program for residents who did not participate or seldom participated in group activities. The activity director stated she lacked the educational background to identify residents who required one to one activities. 5. Review of the 2/20/07 initial Minimum Data Set (MDS) assessment for resident #80 revealed the resident enjoyed music, reading, conversation, and watching television. Review of the 2/12/07 admission activity assessment revealed the resident "Tends to self isolate." Review of the 2/22/07 care plan for activities revealed the resident was not interested in group activities. However, there was no evidence activity staff offered or attempted to provide 1:1 visits for this resident to build on his/her interests in music, reading or conversation. Review of activity records for the resident revealed s/he participated in no activities during the months of March and April 2007. 6. Review of the 11/2/06 significant change MDS assessments for resident #79 revealed s/he enjoyed cards, watching television, and conversation. Review of the 10/31/06 care plan revealed the resident enjoyed a few group activities including bingo and socials. Continued review of the care plan revealed the resident enjoyed playing cards with staff and volunteers. However, review of activity participation records revealed the resident participated in only eight activities during the month of March 2007 and in only five activities to date in April (19th) 2007. According to the activity director on 4/19/07, the resident had decline in his/her activity pursuits. However, there was no evidence staff had	F 248		

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F 248	Continued From page 18 offered or attempted 1:1 visits to engage the resident in conversation or a card game to increase his/her level of activities. 7. Review of the 6/5/06 annual MDS assessment for resident #62 revealed s/he enjoyed religious activities, watching television, and conversation. Review of the 3/07 recreation progress notes revealed the resident was on the 1:1 program three times per week. However, review of the medical record revealed there were no activity goals or individualized approaches for 1:1 visits. In addition, there was no responsiveness to 1:1 visits documented. 8. Review of the 11/27/06 annual MDS assessment for resident #63 revealed s/he enjoyed reading and conversation. Review of the 11/20/06 RAP for activities revealed the resident "can become disruptive by crying." "We will visit ... [him/her] on our 1 to 1 program 3x week." Review of the 3/8/07 recreation progress notes revealed the resident enjoyed music, being read to and having people talk with him/her. However, review of the medical record revealed there were no activity goals or individualized approaches for 1:1 visits. In addition, there was no responsiveness to 1:1 visits documented. 9. Review of the 1/21/07 initial MDS assessment for resident #68 revealed s/he enjoyed cards, games, and conversation. Review of the 1/15/07 admission activity assessment revealed the resident liked bingo. Review of the 1/18/07 care plan revealed the resident did not like group activities other than bingo. Review of the 3/07 and 4/07 activity records for the resident revealed s/he had not participated in any activities at all. In addition, there was no evidence activity staff had	F 248		

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F 248	Continued From page 19 offered or attempted 1:1 visits with the resident to play cards, games or have a conversation.	F 248		
F 249 SS=E	483.15(f)(2) ACTIVITY DIRECTOR QUALIFICATIONS The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure the activity program was under the direction and/or oversight of a qualified professional. The facility census was 82. The findings were: An initial interview with the activity director on 4/16/07 at 3:28 PM revealed she had been at the facility since September 2006 as a activity assistant, and assumed the director position when the previous director left. Further interview revealed she lacked educational background and/or experience for the position. The director stated the activity program was not under the oversight of anyone else and she was	F 249	**F249 Activity Director Qualifications** The Activity Program will be directed by a qualified professional. A contract has been entered into between the facility and an individual who has completed the State approved training program. This contract will remain in place until the Activity Director is able to complete the State approved program in the fall. The Activity Consultant will be responsible for the oversight regarding activity programs and care planning for residents. She will meet with the Activity Director at least weekly initially and then on an as needed basis. The Administrator has overall responsibility.	5/31/07

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F 249	Continued From page 20 responsible for the program. During random observations on 4/17/07 of residents #2, #12, and #49, the observations revealed these residents lacked involvement in activities. Interview with the activity director on 4/18/07 at 10:43 AM revealed she confirmed the resident did not attend or consistently participate in group activities. She further stated that she had not considered planning a one to one program for residents who did not participate or seldom participated in group activities such as the aforementioned residents. The activity director stated she currently lacked the educational background to identify residents who required one to one interventions for activities. Further interview revealed she had just continued with the same program the previous director had in place except for deleting some group activities which the residents did not want and adding those activities which residents had suggested. The director identified the one to one program currently had six residents, #25, #55, #62, #66, #73, and #63, in a one to one program. When asked, the director stated she did not have goals or document responses for those residents in a one to one program, nor did she have goals for those residents who attended group activities.	F 249		
F 250 SS=G	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 250		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 250	Continued From page 21 Based on observation, staff interview, and medical record review, the facility failed to ensure social services was provided for 6 (#2, #12, #40, #68, #79, #80) of 10 sample residents with psychosocial needs. The findings were: 1. Review of the 3/07 physician's orders for resident #68 revealed s/he was admitted on 1/24/07 with diagnosis including CVA (cerebrovascular accident-stroke), COPD (chronic obstructive pulmonary disease) and neurogenic bladder. Review of the 1/12/07 admission nursing notes revealed the resident was admitted for a short stay respite care. Review of the 1/15/07 admission social service assessment revealed the resident did not make frequent negative statements, did not have unrealistic fears, did not have frequent repetitive questions and verbalizations such as "help me," did not express sadness, did not express feelings of anxiety, did not demonstrate any anxious behaviors, did not express concerns about sleeping patterns, and had not had any recent change in mood or behaviors. Review of the 1/18/07 (3 days later) social services notes revealed the resident "....can be very demanding at times." "...[s/he] also has periods of restlessness and has experienced some insomnia..." "Rt [resident] also has repetitive health concerns..." Review of the 1/13/07 3 AM nursing notes revealed the resident had been very restless and calling for the nurse to check his/her catheter because s/he felt it was not draining; the resident also stated s/he couldn't feel any oxygen coming through the nasal cannula. Review further revealed "...[the resident] has not been asleep all noc, ringing call light every 45 min [minutes] to every 1 hour." Review of the 1/14/07 6 AM nursing notes revealed the	F 250	**F250 Social Services** The Facility will provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Resident #68 will be reassessed to determine medically necessary social services to assist him/her with pain relief and other concerns. Resident #80 will be assessed for depression. Referrals and interventions will be implemented based on the assessment. Resident #40 will be interviewed with him/her family to document grievances and concerns. The Social Service Director will then investigate these issues and work toward resolution with the family and resident. Resident #12 will be reassessed and a care plan will be developed based on that assessment. Resident #2 will be reassessed and a care plan developed with interventions to assist the staff with his/her sexual aggression. Resident #79 will be reassessed and then care planned to help minimize his/hers resistance to care and verbal abuse. The SSD will interview staff and review all resident records so that residents with behaviors that affect others or behaviors that may be distressing to him/her,	

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F 260	Continued From page 22 resident was very obsessed about his/her catheter irrigation and that s/he was "upset & begging too hard." Review of the 1/15/07 12:40 AM nursing notes revealed the resident was still "obsessed" with his/her catheter irrigation. Documentation revealed the resident was "very demanding" and did not sleep well despite being medicated. Review of the 1/19/07 11:30 AM nursing notes revealed the resident complained of knee pain. Review of the 1/20/07 6 PM nursing notes revealed the resident complained bitterly about pain in his/her left knee and stated the medications were not controlling the pain. Review of the 1/22/07 6 AM nursing notes revealed the resident turned the call light on "every 5 mins [minutes] to go to [the] ER [emergency room]" because the pain in his/her left knee "are killing ... [him/her]" and the medications were not providing relief. Review of the 1/22/07 1 PM nursing notes revealed there was a large bruise on he left shin with faint bruising to the ankle and there was 2+ edema to the left foot. Review of the night nursing notes for 1/22/07 revealed the resident continued to have pain, redness, and bruising in the left leg. Review of the medical record revealed an x-ray was taken on 1/23/07 with the results being probable osteoporosis and severe atherosclerotic calcification in the visualized vessels of the left leg. Review of the 2/1/07 4 PM nursing notes revealed the resident was gotten up for a shower and the certified nurse aide (CNA) reported it sounded like the left lower leg "bones grinding." Review of the 2/1/07 8:20 PM nursing notes revealed the resident complaint of left lower leg pain and nursing noted a small deformity with the appearance of bones sliding. Review of the 2/2/07 6:30 AM nursing notes revealed the nurse called the physician and obtained an order to send the resident to the ER.	F 250	including but not limited to depressive symptoms will receive medically related social services including but not limited to referrals to appropriate outside resources and care planning with interventions to minimize distressing behaviors. The Social Service Director will report to the QA Committee the number of referrals made and progress toward reductions in resident behavior. The Social Service Director is responsible for overall compliance.	5/31/07

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F 250	Continued From page 23 Continued review of these notes revealed the resident had a tibia/fibula fracture with minimal displacement. Review of the 2/2/07 10:35 PM nursing notes revealed the resident complained of severe pain and required both OxyContin (pain med) 10 milligrams and Percocet (pain med) to relieve the pain. Review of the 2/7/07 3:10 AM nursing notes revealed the resident had more pain than usual and did not sleep at all. Further review revealed the resident was "begging for pain medicine." Review of the 2/8/07 11 PM nursing notes revealed the resident was using the call light frequently and was yelling out "help." Review of the 2/8/07 midnight nursing notes revealed the resident almost continually yelling out "help," was very confused and did not recognize the nurses, and was groggy to the extent that staff "Literally had to help" the resident with drinking water Review of the 2/12/07 nursing notes, timed at 5 AM, revealed the resident had increased left lower extremity pain; was administered two percocet (pain med), 1 OxyContin (pain med) and Ambien (hypnotic for sleep) without pain relief or being able to sleep. Record review also revealed the resident used the call light every five to ten minutes and had increased confusion. Review of nursing notes dated 3/7/07 at 3 AM revealed the resident was using the call light every five to ten minutes, was given three pain medications and one sleeping pill but did not sleep, was unable to be re-directed, and was not comprehending what staff told him/her. Review of the 2/27/07 hospital record revealed the resident had a cystoscopy with fragmentation of bladder stones on 3/8/07. Review of the 3/18/07 6 PM nursing notes revealed the resident was "obsessing" about getting the catheter bag emptied "10 times/day." Staff also documented: "Puts on call light	F 250		

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F 250	Continued From page 24	F 250		

constantly until emptied." Review of the nursing notes documented on 3/19/07 at 1 AM revealed the resident remained awake despite being given Xanax (antianxiety), Ambien (hypnotic), and Percocet (pain med) twice. Further review revealed the resident was "Obsessed about emptying SPC - unable to re-direct. whiny." Review of the 3/28/07 night nursing notes revealed there was a "sore/ulcer" on top of the resident's left foot with soft edema and the splint seemed not in alignment. Review of the 4/4/07 (6 days later) 5 PM nursing notes revealed "Noted open areas on top of foot---one scabbed. Area is very puffy with soft edema and a faint purple color. Will see about appt [appointment] with orthopedist to have this evaluated." Review of the 4/5/07 4 PM nursing notes revealed the resident returned from the clinic with a recommendation for amputation of the left foot due to the lack of healing as well as pain. Review of the 4/16/07 10:30 AM nursing notes revealed the resident's foot was "...out of splint--entire heel is necrotic and there is bloody drainage. Also top of foot has necrosed--bloody drainage." Review of the nursing notes dated 4/16/07 at 2 PM revealed the resident stated, "Just let me die--you are selfish for keeping me alive." Review of the entire medical record revealed no evidence social services intervened to provide counseling or support for this resident who initially had been admitted for respite care, then underwent a series of medical problems including pain, broken bones, ulcers and a possible amputation. Interview with the social services director on 4/19/07 at 11:20 AM confirmed she had not worked with this resident but that she was "going to."

2. Review of the face sheet for resident #80

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F 250	Continued From page 25 revealed s/he was admitted on 2/12/07. Review of the social service admission assessment revealed the resident was somewhat depressed about placement and was not eating well, had a low energy level, and was not motivated to get better. Review of the 3/19/07 social service progress notes revealed the resident was lethargic, and "...has been in a depressed mood since admitted." Review of the 2/16/07 psychotropic drug use Resident Assessment Protocol (RAP) report revealed the resident lacked "motivation" at this time. According to the documentation, the resident had preferred "...to lay in bed and sleep all the time." ...showing "very little interest in anything." In addition it was documented that the resident had "no appetite." The documentation further revealed the resident was on a "low dose" of Lexapro and Klonopin at bedtime for "anxiety and depression." Review of the 2/16/07 ADL [activities of daily living] RAP report revealed "...lacks interest in surroundings ...prefers to spend all ...time in bed dozing...lacks motivation for care and is probably capable of doing more than ...[s/he] is currently doing." Review of the 2/12/07 activity assessment revealed the resident tended to "self isolate." Periodic observation from 4/16/07 at 2 PM through 4/19/07 at 5 PM revealed the resident did not leave his/her room, except for meals. Review of the medical record revealed there had been no comprehensive assessment performed to evaluate the resident's signs and symptoms of depression. During an interview with the social service director on 4/18/07 at 11:20 AM, she confirmed she had not assessed the resident's signs and symptoms of depression, but that she should have. In addition, the social service director stated she had not provided any counseling, interventions, or referrals to address	F 250		

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F 250	Continued From page 26 the resident's signs and symptoms of depression. 3. Interview 4/17/07 at 5:41 PM with a family member for resident #40 revealed the family had voiced concerns "a number of times" related to care issues, cleanliness of the resident's environment, and food issues. The family member voiced frustration related to the lack of response by the facility. Review of the resident's medical record showed no active social service interventions in place. Interview with the social worker on 4/19/07 at 10:05 AM revealed she was not involved with the family or their concerns since the issues were not "behavioral;" any grievances were routinely directed to the individual department heads. 4. Random observations of resident #12 on 4/17/07 from 7:46 AM until the resident went into the dining room at 11 AM revealed the resident spent the morning wandering. Review of the medical record revealed the April 2007 medication administration record (MAR) which showed the resident took Ativan, an antianxiety medication, on 16 of 17 days in April and on 25 of 31 days in March 2007. The medication was ordered as needed. Interview with the social worker on 4/19/07 at 10:05 AM revealed she was aware the resident typically attempted to leave in the afternoon and exhibited extreme anxiety. She stated she was unaware of the almost daily use of the medication. According to this interview, the social worker's interventions for this resident were limited to reviewing the MAR and behavior tracking sheets each quarter. 5. Review of the medical record revealed nursing notes for resident #2 which documented on	F 250		

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F 250	Continued From page 27 11/27/06, 12/31/06, 1/24/07, 3/2/07 and 4/10/07 the resident displayed inappropriate sexual aggression toward care givers. Review of the social service progress notes revealed the behaviors were mentioned in the most current documentation dated 1/22/07. Interview with the social worker on 4/19/07 at 10:05 AM revealed she dealt with resident behaviors by monitoring the nurses notes and verbally reminding staff the actions were a result of the resident's diagnoses. 6. Review of the 3/07 physician's orders for resident #79 revealed s/he was admitted with diagnosis including traumatic brain injury and depression. Review of the 2/1/07 social services notes revealed s/he was verbally abusive to staff at times and resisted care. Review of the medical record revealed no evidence social services provided counseling or interventions to address these psychosocial issues.	F 250		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observations, staff and family interview, the facility failed to assure adequate maintenance and repair of four resident doors, one resident bathroom lighting fixture, and one resident walker. In addition, random observation revealed the facility failed to assure two resident toilets were cleaned and sanitized in a timely manner. The findings were: Observations during the environmental tour on	F 253	**F253 Housekeeping/Maintenance** The Facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Kicks guards will be cleaned. Kick guards with pieces missing will have them replaced, including rooms #52, #55, and #59 Bathroom doors in rooms #11 and #55 will be repaired or replaced. Lights in residents' rooms will be reviewed to see if they need replacement including room #39 The Facility will assure that bathrooms and tub rooms will be cleaned timely when soiled.	

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F 253	Continued From page 28 4/18/07 at 1:10 PM revealed the following concerns: a. Doors throughout the facility had kick guards which had black scuffs. b. Kick guards on resident doors had pieces missing which left an unsightly unfinished wood surface to door on rooms #52, #55, and #59. Sections missing measured 1 inch by 3 feet on room doors #52 and #55. Apiece approximately 1 inch by 12 inches was missing from the room door #59. c. Bathroom door in rooms #11 and #55 has white wood patching material applied to fill in damaged wood. d. In addition, during observations of care on 4/17/07 and 4/19/07 the bathroom light in room #39 was dimly lit and flickered when turned on. Interview with certified nurse aides #15 and #22 on 4/18/07 at 11:46 AM revealed nursing staff had not been placed a work order to notify maintenance of the faulty light. e. Observation on 4/17/07 at 2:13 PM revealed feces in the toilet and on the toilet seat in the men's shower room. Interview with bath aide on 4/18/07 at 8:48 AM revealed the feces was not cleaned until the following day. She stated upon her arrival to work at 6:30 AM she called housekeeping and they came and cleaned it up a short time later. f. Interview with a family member for resident #40 (who resides in room #55) on 4/17/07 at 5:41 PM revealed the family notified the facility " a number of times" related to their concerns	F 253	Resident #40 will have issues related to cleanliness addressed in a timely manner. Resident #79 has had his/her walker repaired. All Staff will be in-serviced on by May 14th regarding their responsibilities involving cleanliness of the facility. The Administrator will do rounds with maintenance and housekeeping staff daily for 3 weeks to assure cleanliness and general order. The DON will do rounds daily with nursing staff for 3 weeks to assure cleanliness and general order After the 3 weeks, rounds will be done on a random basis. Documentation of rounds will be kept and reviewed. Areas found to be deficient will be addressed immediately. The DON will compile a report from the rounds documentation for the QA Committee monthly for the next 3 months and then quarterly. The Administrator is responsible for overall compliance.	5/31/07

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F 253	Continued From page 29 which include urine and feces on toilet seats, as well as, the general cleanliness and appearance of the environment. g. Observations from 4/16/07 through 4/19/07 at 12 noon revealed resident #79 had a walker with built up handle grips. The built up area on the left was covered with tape which had some jagged edges.	F 253		
F 272 SS=D	483.20, 483.20(b) 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 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; 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	F 272	**F272 Comprehensive Assessments** The Facility will assure that comprehensive, accurate, standardized reproducible assessments will be conducted initially and periodically for each resident's functional capacity. Resident #82 will have documented reassessment for the use of his/her merry walker. Resident #2 will have documented reassessment for the use of the lap belt. Resident #68 will be assessed for the use of a hypnotic to assist with sleep. Resident #80 will receive a comprehensive assessment for depression. An audit of charts and a physical audit of residents will be conducted to identify any other residents with assessment that are missing or late. The Social Services Director will be notified when ever a resident is experiencing difficulty with mood and/or behavior. The SSD will complete a comprehensive assessment related to these issues initially and then at least	

cause of sleeplessness added per request of ADON via telephone on 5/1/07 @ 350 Linda Burton RN

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F 272	Continued From page 30 resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a comprehensive assessment was completed in a variety of areas for four (#2, #68, #80, #82) of 14 sample residents. The findings were: 1. Periodic observations from 4/16/07 at 2 PM through 4/19/07 at 11 AM revealed resident #82 utilized an enclosed framed wheeled walker (merry walker restraint) at times. Observation and attempted interview with the resident on 4/18/07 at 2 PM revealed the resident was unable to open the front gate and exit the device. Interview with registered nurse (RN) #10 on 4/18/07 at 2:10 PM confirmed the resident was unable to open the gate and exit the device. The following concerns with restraint utilization were identified: a. Review of the medical record revealed the most current restraint assessment was completed on 9/6/05 (1 year 7 months ago). Review of that assessment revealed the medical symptom that led to the consideration of the use of restraints was identified as "organic brain syndrome." According to Taber's Cyclopedic Medical Dictionary, 19th edition, 2001, pages 557 -558, 453-455, and 2018, organic brain syndrome is a medical diagnosis. The same source defined medical diagnosis as the identification of the cause of a persons' illness or symptoms. Finally, the source defined symptom as the subjective experience of disease. b. Review of the 3/8/07 care plan revealed the following: "Extensive assist with 1 for	F 272	quarterly. Then based on the assessment a care plan with interventions to minimize these issues will be established. The care plan will be communicated to the nursing staff. The DON will be notified when ever a resident is in need of a device to assist with positioning or to be used as a physical restraint. The DON will conduct an initial assessment and then develop a care plan based on the assessment. The use of the device will be assessed at least quarterly. An audit will be conducted monthly for the next 3 months; results will be reported to the QA Committee. Deficient practices will be corrected immediately. The DON and Social Service Director are responsible for overall compliance.	5/31/07

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....ambulating. Limited with 1 for locomotion short distances. Staff assists to meals. Res. [resident] will walk with assist of 1 if staff puts their hands out for ... [the resident] to hold onto." "Staff must take to locations." Continued review of the care plan revealed the utilization of the merry walker as a restraint was not addressed. Use of the merry walker was identified only as a goal and a strength under the "Impaired physical mobility" problem and as a means for ambulation under the problem "Potential for falls."

c. Review of the entire medical record revealed there was no evidence an evaluation of the effectiveness of the restraint was performed since 9/6/05. There was no evidence elimination or reduction of restraint utilization was considered since 9/6/05. Finally, there was no evidence that less restrictive measures were considered or attempted since 9/6/05.

2. Observation on 4/17/07 at 9:52 AM revealed resident #2 was seated in a wheelchair wearing a lap belt. At the time, the resident requested the surveyor remove the belt. A staff member nearby heard the request, and upon talking with the resident, found the resident's right fingers had become entangled in the belt; the resident could not independently free his/her hand. Observation and interview with the resident on 4/18/07 at 2:42 PM revealed s/he was not as alert as the previous morning, and was not able to release the belt when ask to do so. Review of the medical record revealed the residents most recent Minimum Data Set assessment, a quarterly assessment dated 1/29/07, revealed at the time of the assessment, the resident had both short term and long term memory problems, had moderately impaired cognition, and required extensive to total assistance with bed mobility

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

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F 272	Continued From page 32	F 272		

and transfer. The assessment documented at that time, ambulation did not occur during the assessment period and the resident had not utilized a restraint. Further record review, failed to reveal an assessment for the lap belt as a restraint, and/or information with regard to the ability for the resident to use the belt safely. Interview and medical record review with the DON on 4/19/07 at 9:01 AM revealed she was unable to find any assessment for the lap belt.

3. Review of the 3/07 physician's orders for resident #68 revealed an order for Ambien (sleep medication) 10 milligrams (mg) as needed for insomnia. However, review of the entire medical record revealed there was no evidence an assessment for the cause of the resident's insomnia was performed. Interview with the DON on 4/18/07 at 11:20 AM confirmed there was no assessment for the cause of the insomnia performed.

4. Review of the face sheet for resident #80 revealed s/he was admitted on 2/12/07. Review of the social service admission assessment revealed the resident was somewhat depressed about placement and was not eating well, had a low energy level, and was not motivated to get better. Review of the 3/19/07 social service progress notes revealed the resident was lethargic, and "...[s/he] has been in a depressed mood since admitted." Review of the 2/16/07 psychotropic drug use Resident Assessment Protocol (RAP) report revealed the resident "lacks any motivation at this time. ...[s/he] prefers to lay in bed and sleep all the time. ...[s/he] show very little interest in anything and has no appetite." "...[s/he] is on a low dose of Lexapro and Klonopin at HS [bedtime] for anxiety and

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F 272	Continued From page 33 depression." Review of the 2/16/07 ADL [activities of daily living] RAP report revealed "...lacks interest in surroundings." "...prefers to spend all ...time in bed dozing." "...lacks motivation for care and is probably capable of doing more than ...[s/he] is currently doing." Review of the 2/12/07 activity assessment revealed the resident "Tends to self isolate." Review of the medical record revealed there was no comprehensive assessment performed to evaluate the resident's signs and symptoms of depression. During an interview with the social service director on 4/18/07 at 11:20 AM, she confirmed she had not performed an assessment of the resident's signs and symptoms of depressions but that she should have.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's 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).	F 279		

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F 279	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure a care plan was developed for two (#12, #79) of 14 sample residents. The findings were: 1. Medical record review for resident #12 revealed the residents most recent Resident Assessment Instrument (RAI) was an annual assessment with an R2b date of 4/9/07. Review of the assessment showed the resident triggered for pressure sores and a decision was made to proceed to with developing care plan interventions. Review of the care plans failed to reveal interventions for pressure sores even though the assessment documented the resident had a pressure sore in the last 90 days. Interview with the director of nursing on 4/18/07 at 3:10 PM revealed she was unable to find a care plan for pressure sores even in the purged record. 2. Review of the 3/07 physician's orders for resident #79 revealed s/he had an allergy to bleach. Further review revealed the resident's laundry had to be washed separately and without bleach; also the linens used for this resident. Review of the 2/6/07 care plan revealed staff identified the problem "Potential for eczema type rash R/T [related to] allergies to bleach..." however, the instructions to wash the resident's clothing and linen separately and without bleach was not addressed. Observation of the resident's legs during perineal care revealed s/he had a rash on the legs and was scratching them. Interview with CNA #28 on 4/19/07 at 10:35 AM revealed he was unaware of the resident's	F 279	**F279 Comprehensive Care Plans** The Facility will assure that it uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive assessment. Resident # 12 will have a care plan developed for the prevention of pressure ulcers related to a history of pressure ulcers. Resident # 79 will have a care plan developed for his/her sensitivity to bleach. The MDS Coordinator will do an audit of all resident's chart to identify if any other residents may have issues that have not been care planned. Any care plan that is not present will be implemented. The MDS Coordinator will audit charts prior to each care conference to assure that all necessary care plans are present. Any deficient practices will be corrected immediately by the qualified individual responsible. The MDS Coordinator will compile a report related to care plans developed from the comprehensive assessments. It will be presented to the QA Committee monthly for the next 3 months and then quarterly. The MDS Coordinator will be responsible for overall compliance.	5/31/07

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F 279	Continued From page 35 allergies.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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, staff interview and medical record review, the facility failed to ensure care plan revisions for one (#49) non-sample resident. The findings were: Observation on 4/18/07 at 5:29 PM revealed an unidentified staff member pulling resident #49 by the arm down the hall. The resident was seated in a wheelchair at the time. Medical record review revealed no current care plan interventions for the observed mobility assistance. Interview with the director of nursing (DON) 4/19/07 at 9:07 AM revealed the	F 280	**F280 Comprehensive Care Plans** The Facility will assure that resident's care plans are periodically reviewed and revised by a team of qualified persons after each assessment. Resident #49 will have his care plan revised to indicate his/her preferred type of assistance with mobility. The MDS Coordinator will do an audit of all resident's chart to identify if any other residents may have issues that have not been care planned. Any care plan that is not present will be implemented. The MDS Coordinator will audit charts prior to each care conference to assure that all necessary care plans are present. Any deficient practices will be corrected immediately by the qualified individual responsible. The MDS Coordinator will compile a report related to care plans that are reviewed and revised by the qualified persons after each assessment. It will be presented to the QA Committee monthly for the next 3 months and then quarterly. The MDS Coordinator will be responsible for overall compliance.	5/31/07

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F 280	Continued From page 36 observation made by the surveyor was the resident's preferred manner in which to get assistance. The DON stated the method should be documented in the care plan.	F 280		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS 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, staff interview, and medical record review, the facility failed to ensure staff followed the care plans for three (#68, #79, #80) of 11 sample residents. The findings were: 1. Review of the 3/07 physician's order sheet for resident #79 revealed s/he had diagnosis including depression and was on the medication Lexapro (antidepressant). Review of the 2/6/07 care plan revealed "Potential for medication side effects" was identified as a problem. Review of the approaches to that problem included monitoring for signs and symptoms of depression such as isolating self or negative statements. Review of the entire medical record and the 3/07 and 4/07 Medication Administrations Records (MARs), the Treatment Administration Records (TARs), and the behavior monitoring forms revealed no evidence the resident was monitored for depressive symptoms. Interview with the social service director on 4/19/07 at 11:20 AM revealed she was unaware the resident's depressive symptoms were not being monitored.	F 282	**F282 Comprehensive Care Plans** The Facility will assure that services are provided or arranged with qualified persons in accordance with each resident's written plan of care. Resident #79 and Resident #80 will have signs and symptoms of depression monitored. Resident #68 will have signs and symptoms of pain and adequacy of pain medications documented. The MDS Coordinator will review all care plans and assure that there are proper monitoring tools for each area that needs to be tracked. When ever a deficiency is noted, the MDS Coordinator will meet with the responsible discipline to assist them in development of a monitoring tool. The MDS Coordinator will compile a report related to monitoring tools that will assist with comprehensive assessments. It will be presented to the QA Committee monthly for the next 3 months and then quarterly. The MDS Coordinator will be responsible for overall compliance.	5/31/07

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F 282	Continued From page 37 2. Review of the face sheet for resident #80 revealed s/he was admitted on 2/12/07. Review of the social service admission assessment revealed the resident was somewhat depressed about placement and was not eating well, had a low energy level, and was not motivated to get better. Review of the 3/19/07 social service progress notes revealed the resident was lethargic, and "...[s/he] has been in a depressed mood since admitted." Review of the 2/16/07 psychotropic drug use Resident Assessment Protocol (RAP) report revealed the resident "lacks any motivation at this time. ...[s/he] prefers to lay in bed and sleep all the time. ...[s/he] show very little interest in anything and has no appetite." "...[s/he] is on a low dose of Lexapro and Klonopin at HS [bedtime] for anxiety and depression." Review of the 2/16/07 ADL [activities of daily living] RAP report revealed "...lacks interest in surroundings." "...prefers to spend all ...time in bed dozing." "...lacks motivation for care and is probably capable of doing more than ...[s/he] is currently doing." Review of the 2/12/07 activity assessment revealed the resident "Tends to self isolate." Periodic observations from 4/16/07 at 2 PM through 4/19/07 at 5 PM revealed the resident never left his/her room except for meals. Review of the 2/18/07 care plan revealed the resident should be monitored for signs and symptoms of depressions such as sad facial expression and negative statements on the behavior sheet every shift. Review of the medical record, the 3/07 and 4/07 MARs, TARS, and behavior monitoring sheets revealed there was no evidence the resident was being monitored for depressive symptoms. During an interview with the social service director on 4/19/07 at 11:20 AM, she stated she was unaware the care plan was not	F 282		

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F 282	Continued From page 38 followed. 3. Review of the nursing notes for resident #68 revealed s/he had severe and frequent episodes of pain from bladder stones, a tibia/fibula fracture, and a severe wound on his/her left foot. Review of the 1/19/07 care plan revealed staff should monitor for adequate pain relief. Review of the 3/07 MAR revealed the resident received pain medications 60 times. Continued review revealed the effectiveness of the medication was not indicated 32 of the 60 (53%) times medications for pain were administered.	F 282		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure appropriate care and treatment of pain and a newly identified pressure sore to prevent harm for one (#68) of two sample residents with pressure sores. The findings were: 1. Review of the 3/28/07 interdisciplinary progress notes for resident #68 revealed "L [left] top of foot has sore/ulcer noted, soft edema noted thus unable to palpate pulse...." "L [left] leg with splint seems not in alignment..." Continued review of the interdisciplinary progress notes	F 309	**F309 Quality of Care** The Facility will assure that each resident will receive 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. Resident #68 will receive necessary care and services to meet his/her needs, including but limited to pain management and wound care. An audit will be completed of all resident charts to assure that all residents are receiving care and services to meet their needs. All staff will be in-serviced by May 14th regarding the importance of good communication and good reporting. Nursing staff will receive additional in-servicing on May 21st and May 22nd including but limited to pain management and reporting systems.	

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F 309	Continued From page 39 revealed the next note regarding the newly identified pressure ulcer was written on 4/4/07 at 5 PM by nursing: "Noted open areas on top of foot - scabbed. Area is very puffy with soft edema and a faint purple color. Will see about appt [appointment] with orthopedist to have this evaluated." A nursing note documented on 4/5/07 at 4 PM revealed that the resident returned from the clinic with a recommendation for amputation of the left foot due to the non-healing and pain. The following concerns were identified: a. Medical record review revealed the physician was not notified of the pressure ulcers from the first entry on 3/28/07 until 4/4/07 (seven days) later. b. Interview with the director of nursing on 4/18/07 at 11 AM confirmed there was no evidence the physician was called or any treatment was provided prior to the seventh day after initial identification of the ulcer. c. Review of the 4/16/07 10:30 AM nursing notes revealed "Observed foot out of splint entire heel is necrotic and there is bloody drainage. Also top of foot has necrosed - bloody drainage." d. Review of the 4/16/07 2 PM nursing notes revealed the resident stated , "Just let me die-you are selfish for keeping me alive." In addition, observation on 4/17/07 at 8:55 AM revealed the resident asked for a pain pill. Continued observation and review of the 4/07 MAR and nursing notes revealed the resident did not receive anything for pain until 10:30 AM (1 hour and 35 minutes later). Review of the 3/07 physician's orders revealed the resident received OxyContin (pain medication) at 8 AM routinely, but also had an order for Percocet 1-2 tablets as needed for breakthrough pain. Review of the 4/07 MAR revealed the resident had not received	F 309	The Director of Nursing will review the 24-hour reports and the CNA report sheets on a daily basis. Any changes of condition will be reviewed to assure that proper physician notification has occurred. The DON will track the notification process and write a report for the QA committee with the results monthly for the next 3 months and then quarterly thereafter. The Director of Nursing is overall responsible.	5/31/07

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F 309	Continued From page 40 Percocet since 2 PM the previous day.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policy and procedure, the facility failed to ensure staff provided adequate perineal care during one (#79) of four observations. The findings were: Review of the 11/2/06 Minimum Data Set (MDS) assessment for resident #79 revealed s/he required total staff assistance with personal hygiene. Observation on 4/17/07 at 9:10 AM revealed the resident was assisted to the toilet by certified nurse aide (CNA) #15 where s/he urinated and had a bowel movement. Continued observation revealed CNA # 15 provided perineal care by cleaning the anal area and then using two short, quick swipes of the washcloth over the resident's genitalia. Review of the facility policy and procedure for perineal care dated 1/01 revealed the instructions for thorough cleansing of the external genitalia following an episode of incontinence. During an interview with the CNA on 4/17/07 at 12 noon, she confirmed she didn't follow the facility's procedure.	F 312	**F312 Activities of Daily Living** The Facility will assure that 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. Resident #79 will receive proper peri care. Nursing staff will be in-service by May 22nd regarding proper peri care for both male and female residents. Return demonstrations will be conducted during the following week. All CNAs must demonstrate proper peri care to their immediate supervisor on or before May 31st. Deficient practices will be corrected immediately and require further observation. After that there will be random observations performed on the nursing stations with residents. Reports of return demonstrations and observations will be given to the DON for review. A Report will be compiled for the QA Committee monthly for the next 3 months and then quarterly. The DON is responsible for overall compliance.	5/31/07
F 320 SS=D	483.25(f)(2) MENTAL AND PSYCHOSOCIAL FUNCTIONING	F 320		

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F 320	Continued From page 41 Based on the comprehensive assessment of a resident, the facility must ensure that a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff met psychosocial adjustment needs for two (#68, #80) of four sample residents added during the previous 3 months. The findings were: 1. Review of the 3/07 physician's orders for resident #68 revealed s/he was admitted on 1/24/07 with diagnosis including CVA (cerebrovascular accident-stroke), COPD (chronic obstructive pulmonary disease) and neurogenic bladder. Review of the 1/12/07 admission nursing notes revealed the resident was admitted for a short stay respite care. Review of the 1/15/07 admission social service assessment revealed the resident did not make frequent negative statements, did not have unrealistic fears, did not have frequent repetitive questions and verbalizations such as "help me", did not express sadness, did not express feelings of anxiety, did not demonstrate any anxious behaviors, did not express concerns about sleeping patterns, and had not had any recent change in mood or behaviors. Review of the 1/18/07 (3 days later) social services notes revealed the resident "....can be very demanding	F 320	**F320 Mental and Psychosocial Functioning** The Facility will assure that residents whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. Resident #68 will receive services that will assist him/her to work on his/her adjustment to the facility. Resident #80 will receive a comprehensive assessment for depression and services to assist him/her to work on his/her adjustment to the facility. An audit of resident charts will be conducted to identify any other residents that may have adjustment issues. All staff will receive in-service training on reporting resident mood and/or behaviors to the SSD. The Social Services Director will be notified when ever a resident is experiencing difficulty with mood and/or behavior. The SSD will complete a comprehensive assessment related to these issues initially and then at least quarterly. Then based on the assessment a care plan with interventions to minimize these issues will be established. The care plan will be communicated to the nursing staff.	

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	535043	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

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F 320	Continued From page 42 at times." "...[s/he] also has periods of restlessness and has experienced some insomnia...". "Rt [resident] also has repetitive health concerns..." Review of the 1/13/07 3 AM nursing notes revealed the resident had been very restless and calling for he nurse to check his/her catheter because s/he felt it was not draining; the resident also stated s/he couldn't feel any oxygen coming through the nasal cannula. Review further revealed "...[the resident] has not been asleep all noc, ringing call light every 45 min [minutes] to every 1 hour." Review of the 1/14/07 6 AM nursing notes revealed the resident was very obsessed about his/her catheter irrigation and that s/he was "upset & begging too hard." Review of the 1/15/07 12:40 AM nursing notes revealed the resident was still obsessed with his/her catheter irrigation. Documentation revealed the resident was "very demanding" and did not sleep well despite being medicated. Review of the 1/19/07 11:30 AM nursing notes revealed the resident complained of knee pain. Review of the 1/20/07 6 PM nursing notes revealed the resident complained bitterly about pain in his/her left knee and stated the medications were not controlling the pain. Review of the 1/22/07 6 AM nursing notes revealed the resident turned the call light on "every 5 mins [minutes] to go to [the] ER [emergency room]" because the pain in his/her left knee "are killing ... [him/her]" and the medications were not providing relief. Review of the 1/22/07 1 PM nursing notes revealed there was a large bruise on he left shin with faint bruising to the ankle and there was 2+ edema to the left foot. Review of the night nursing notes for 1/22/07 revealed the resident continued to have pain, redness, and bruising in the left leg. Review of the medical record revealed an x-ray was taken on 1/23/07 with the	F 320	The SSD will compile a report for the QA Committee regarding the number of residents identified with adjustment problems and interventions implemented to assist them with this. The Social Service Director is responsible for overall compliance.	5/31/07

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F 320	Continued From page 43	F 320		

results being probable osteoporosis and severe atherosclerotic calcification in the visualized vessels of the left leg. Review of the 2/1/07 4 PM nursing notes revealed the resident was gotten up for a shower and the certified nurse aide (CNA) reported it sounded like the left lower leg "bones grinding". Review of the 2/1/07 8:20 PM nursing notes revealed the resident complaint of left lower leg pain and nursing noted a small deformity with the appearance of bones sliding. Review of the 2/2/07 6:30 AM nursing notes revealed the nurse called the physician and obtained an order to send the resident to the ER. Continued review of these notes revealed the resident had a tibia/fibula fracture with minimal displacement. Review of the 2/2/07 10:35 PM nursing notes revealed the resident complained of severe pain and required both oxycontin (pain med) 10 milligrams and Percocet (pain med)to relieve the pain. Review of the 2/7/07 3:10 AM nursing notes revealed the resident had more pain than usual and did not sleep at all. Further review revealed the resident was "begging for pain medicine." Review of the 2/8/07 11 PM nursing notes revealed the resident was using the call light frequently and was yelling out "help". Review of the 2/8/07 midnight nursing notes revealed the resident almost continually yelling out "help", was very confused and did not recognize the nurses, and was groggy to the extent that staff had to "Literally had to help ... [him/her] with ...[him/her] water." "...[s/he] was trying at 1st to such water from an empty cup then was trying to drink form ...[him.her] other cup upside down with the water dripping on ... [him/her]." Review of the 2/12/07 5 AM nursing notes revealed the resident had increased left lower extremity pain; was administered 2 percocet (pain med), 1 Oxycontin (pain med) and

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Ambien (hypnotic for sleep) without pain relief or being able to sleep. Continued review revealed the resident used the call light every five to ten minutes and had increased confusion. Review of the 3/7/07 3 AM nursing notes revealed the resident used the call light every five to ten minutes, was given 3 pain medications and a sleeping pill but did not sleep, was unable to be re-directed, and was not comprehending what staff told him/her. Review of the 2/27/07 hospital record revealed the resident had a cystoscopy with fragmentation of bladder stones on 3/8/07. Review of the 3/18/07 6 PM nursing notes revealed the resident was "obsessing" about getting the catheter bag emptied "10 times/day." "Puts on call light constantly until emptied. Review of the 3/19/07 1 AM nursing notes revealed the resident remained aware even after being given Xanax (antianxiety), Ambien (hypnotic), and percocet (pain med) twice. Further review revealed "Obsessed about emptying SPC - unable to re-direct. whiney." Review of the 3/28/07 night nursing notes revealed there was a "sore/ulcer" noted on the top of the resident's left foot with soft edema and the splint seemed not in alignment. Review of the 4/4/07 (6 days later) 5 PM nursing notes revealed "Noted open areas on top of foot-one scabbed. Area is very puffy with soft edema and a faint purple color. Will see about appt [appointment] with orthopedist to have this evaluated." Review of the 4/5/07 4 PM nursing notes revealed the resident returned from the clinic with a recommendation for amputation of the left foot due to the non-healing and pain. Review of the 4/16/07 10:30 AM nursing notes revealed "Observed foot out of splint-entire heel is necrotic and there is bloody drainage. Also top of foot has necrosed - bloody drainage." Review of the

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F 320	Continued From page 45 4/16/07 2 PM nursing notes revealed the resident stated "Just let me die-you are selfish for keeping me alive." Review of the entire medical record revealed there was no evidence social services intervened to provide support or counseling or support for this resident who only was admitted for respite care then underwent a series of medical problems including pain, broken bones, ulcers and possible amputation. Interview with the social services director on 4/19/07 at 11:20 AM confirmed she had not worked with this resident to assist in his/her adjustment to the facility and to the onset of multiple complications since admission but that she was "going to." 2. Review of the face sheet for resident #80 revealed s/he was admitted on 2/12/07. Review of the social service admission assessment revealed the resident was somewhat depressed about placement and was not eating well, had a low energy level, and was not motivated to get better. Review of the 3/19/07 social service progress notes revealed the resident was lethargic, and "...[s/he] has been in a depressed mood since admitted." Review of the 2/16/07 psychotropic drug use Resident Assessment Protocol (RAP) report revealed the resident "lacks any motivation at this time. ...[s/he] prefers to lay in bed and sleep all the time. ...[s/he] show very little interest in anything and has no appetite." "...[s/he] is on a low dose of Lexapro and Klonopin at HS [bedtime] for anxiety and depression." Review of the 2/16/07 ADL [activities of daily living] RAP report revealed "...lacks interest in surroundings." "...prefers to spend all ...time in bed dozing." "...lacks motivation for care and is probably capable of doing more than ...[s/he] is currently doing." Review of the 2/12/07 activity assessment	F 320		

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F 320	Continued From page 46 revealed the resident "Tends to self isolate." Review of the medical record revealed there was no comprehensive assessment performed to evaluate the resident's signs and symptoms of depression. During an interview with the social service director on 4/19/07 at 11:20 AM, she confirmed she had not performed an assessment of the resident's signs and symptoms of depressions but that she should have. When asked by the surveyor what social services had provided to assist the resident with his/her adjustment to the facility, she stated nothing formally; she stated she had just oriented the resident to his/her room.	F 320		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff performed monitoring for effectiveness and safety of medications for two (#62, #68) of 10 sample residents. The findings were: 1. Review of the 3/22/07 physician's progress notes for resident #62 revealed hi/s/her blood pressure (B/P) was higher than it had been. Further review revealed the physician added Lisinopril (for hypertension) 10 milligrams (mg) to the resident's medication regimen. Continued review revealed the physician requested daily monitoring of the resident's B/P two weeks to determine the effectiveness of the Lisinopril. Review of the 3/22/07 physician's telephone order revealed an order to check the resident's B/P daily for two weeks and send the results by facsimile (fax) to the physician at the end of the two week period. Review of the medical record and Medication Administration Records (MARs) for March and April revealed the resident's B/P was taken on 3/23 through 3/26/07 (4 days), was not taken on 3/26 or 3/27/07, and was again taken on 3/29 through 3/31/07 (3 days). There was no evidence the resident's B/P was again checked until 4/14/07 (14 days later). Review of the entire medical record revealed there was no evidence the results of the B/P checks that were done were faxed to the physician. Interview with the DON on 4/19/07 at 1 PM confirmed the results were not faxed to the physician. 2. Review of the 3/07 physician's orders for resident #68 revealed s/he received Cardura	F 329	**F329 Unnecessary Drugs** The Facility will assure that each resident's drug regimen is free from unnecessary drugs. Resident #62 will have 2 weeks of daily blood pressures faxed to his/her physician as ordered. Resident #68 will have his/her blood pressure monitored as ordered by his/her physician. A chart audit will be conducted to identify any other residents that may not be receiving monitoring of medications as ordered by their physicians. Deficient practices will be corrected immediately. The DON and/or designee will monitor MARs at least weekly to monitor for continued compliance. Any deficient practices will be corrected immediately and individuals found to have continued deficient practices will be disciplined. The DON will compile a report monthly for the next 3 months and then quarterly for the QA Committee with the results of the audits, deficient practices and any discipline that was necessary. The DON is responsible for overall compliance.	5/31/07

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F 329	Continued From page 48 (antihypertensive) and Diltiazem (antihypertensive) for high blood pressure. Review of the 2/25/07 physician's order revealed the resident needed a B/P reading weekly while on these two medications. Review of the 3/07 Medication Administration Record (MAR) revealed the resident's B/P was not taken the first week of March. Review of the 4/07 MAR revealed the residents's B/P was not taken the second week of April. Interview with the DON on 4/19/07 at 1 PM confirmed there was no evidence the resident's B/P was taken during those two weeks.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the	F 334		

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F 334	Continued From page 49 influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	**F334 Influenza and Pneumococcal Immunization** The Facility will develop a system to assure that resident receive information regarding vaccinations for influenza and pneumococcal and are asked what their choices might be. Resident #25, #21, #80, and #68 will receive information regarding vaccinations and if they choose to be vaccinated will receive those vaccinations. An audit will be conducted to identify any other residents that may not have received the information on vaccinations. Any resident that has not will receive the information and be given the vaccinations of their choice. A system will be utilized to assure that all new residents and/or responsible party members receive vaccination information within the first month of admission. Vaccinations will be received based on the wishes of the resident and/or family. The ADON will review all new admissions to assure that information has been sent and received timely. Follow up will continue until signed information is present in the chart. The ADON will compile a report for the QA Committee for 3 months regarding immunization notification and follow up. The ADON will be responsible for overall compliance. 5/31/07	

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F 334	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on medical record review policies and procedures, the facility failed to ensure four (#2, #25, #68, #80) of four newly admitted sample residents. The findings were: Interview with the assistant director of nursing (ADON) on 4/18/07 at 2:13 PM revealed she was responsible for the immunization program. The ADON stated residents admitted after the facility immunizations in the fall were not identified as needing the immunizations for flu and pneumovax. The ADON further stated there currently was not a system in place to identify those residents and which vaccinations they required. Medical record review for vaccinations revealed the following residents did not currently have vaccination information: a. Resident #25 who was admitted on 12/6/06 b. Resident #21 who was admitted on 12/21/06 c. Resident #80 who was admitted on 02/12/07 d. Resident # 68 who was admitted on 01/12/07	F 334		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced	F 371		

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F 371	Continued From page 51 by: Based on observation and staff interview, the facility failed to assure proper handwashing during meal preparation and meal service. The findings were: During the initial kitchen tour on 4/16/07 at 1:20 PM, observation revealed a metal garbage can next to the hand washing sink. The mechanized foot pedal which raised the lid on the garbage can did not work. In addition, another plastic garbage can was observed in the kitchen next to the kitchen stove. A plastic lid covered the can. Observation on 4/16/07 at 3:46 PM revealed two of three kitchen aides washed their hands then immediately lifted one of the garbage can lids in order to throw away the paper hand drying towels. Observation on 4/17/07 at 9:48 AM again revealed three of three kitchen aides did the same thing. In both cases, the aides immediately resumed food preparations tasks. According to the Food Code 2005, U.S. Public Health Service, When to Wash 2-301.14: Food employees shall clean their hands and exposed portions of their arms... (g) when switching between working with raw food and working with ready-to-eat food, (h) before donning gloves for working with food and (I) after engaging in other activities that contaminate the hands. Interview with the dietary manager on 4/18/07 at 9:55 AM revealed staff should wash their hands and change gloves after touching contaminated items such as garbage can lids.	F 371	**F371 Sanitary Conditions – Food Prep & Service** The Facility will store, prepare, distribute and serve food under sanitary conditions. The trash can used for hand washing has been replaced with one that functions properly. The lid lifts by pushing a foot pedal so that dietary staff does not have to handle the lid. Dietary staff will be in-serviced by May 15th regarding the need to inform maintenance immediately of a trash can that malfunctions. Maintenance will replace the trash can immediately. The Dietary Manager will monitor the trash can for proper functioning. Random audits of hand washing will also be conducted within the dietary department to assure that staff performs the skill adequately and understands their reporting responsibilities. The dietary Manager will compile a report for the QA Committee monthly for the next 3 months regarding audit results. The Dietary Manager is responsible for overall compliance.	5/31/07
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional,	F 465		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 52 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for residents, staff and the public. The findings were: 1. During the initial kitchen tour on 4/16/07 at 1:20 PM, observation revealed the doors to the reach-in refrigerator did not form a tight seal. Keys were inserted into each door latch. Posted on the doors was a notice that stated staff was to unlock and then relock the doors prior to and after using the unit in order to maintain a tight closure. 2. Observation on 4/18/07 at 1:10 PM revealed the following concerns: a. The plastic baseboard molding (mop board) in room 31 by the bathroom door was coming away from the wall approximately 4 inches. b. The plastic baseboard in room #36 by the entry door was coming a way from the wall approximately 5 inches. In addition, the entry door had a splintered portion of the kick plate hanging away from the door with sharp, jagged edges. c. The plastic baseboard molding on one side of the archway into the television room across from nurses station 2 was missing and the exposed piece of the mop board was hanging away from the wall exposing a rough corner. The side of the other archway in to the television room had 2 pieces of edge molding broken off approximately 3 feet from the floor exposing	F 465	**F465 Other Environmental Conditions** The Facility will provide a safe, functional, sanitary and comfortable environment for residents, staff, and the public. The reach-in refrigerator will have the door seals replaced. Backflow valve will be installed on the hair salon sink added per request of ADON on 6/1/07 @ 3:50 pm Sandra Brown RN Plastic baseboard molding will be replaced or reattached to the wall which ever is appropriate in rooms 31, 36, the TV room and dining room 2. The Administrator will do rounds with maintenance and housekeeping staff daily for 3 weeks to identify any further issues with plastic baseboard molding. After the 3 weeks, rounds will be done on a random basis. Documentation of rounds will be kept and reviewed. Areas found to be deficient will be addressed immediately. The Administrator will compile a report from the rounds documentation for the QA Committee monthly for the next 3 months and then quarterly. The Administrator is responsible for overall compliance.	5/31/07

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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
	535043	A. BUILDING _____ B. WING _____	04/19/2007

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LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

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F 465	Continued From page 53 sharp pieces of splintered wood. d. The baseboard heater cover in dinning room 2 was bent exposing a sharp edge which projected into the room about an inch. Interview with the maintenance manager on 4/19/07 at 3:38 PM confirmed the above findings represented safety hazards. 3. Observation of the hair salon on 4/18/07 at 12:47 PM revealed the sink lacked a backflow valve. Interview with the maintenance director at that time confirmed the sink did not have a backflow valve.	F 465		
F 467 SS=C	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, the facility failed to provide outside ventilation to five random air ceiling vent. The findings were: During the initial tour on 4/16/07 at 2:10 PM a strong fecal odor was noted in the hall outside of room 9, and a strong urine odor outside of rooms #68, #69, and #70. Observation on 4/18/07 at 12:47 PM revealed an odor of feces in the public bathroom near the beauty shop. Further observation revealed no air movement through the vent in the bathroom, nor the vent in the hallway outside. Observations of vents in bathrooms #55 and # 58 in the second station hall, and #68 in the first station hall revealed no	F 467	**F467 Other Environmental Conditions – Ventilation** The Facility will have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. The air circulation fan motor on the roof has been replaced which will correct the problems with odors and ventilation identified outside rooms 68, 69 and 70, in the public bathroom, and the bathroom in rooms 55, 58, 68 and 23. The Administrator will do rounds with maintenance and housekeeping staff daily for 3 weeks to identify any further issues with ventilation. After the 3 weeks, rounds will be done on a random basis. Documentation of rounds will be kept and reviewed. Areas found to be deficient will be addressed immediately. The Administrator will compile a report from the rounds documentation for the QA Committee monthly for the next 3 months and then quarterly. The Administrator is responsible for overall compliance. added per request (via telephone) of the ADON on 6/11/07 at 3:55 p.m. 5/31/07 Linda Bell RN	

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F 467	Continued From page 54 air flow. Observation of the bathroom window in room 68 revealed it was open. Interview at that time with resident #28 who occupied the room, revealed the bathroom window was open to "get the stink out." Interview with a family member for resident #40 who resides in room #55 on 4/17/07 at 5:41 PM revealed urine and feces odor was a problem which the family had addressed with the facility a number of times." Interview with the facility administrator on 4/19/07 at 3:48 PM revealed the maintenance director told him the air circulation fan motor on the roof was burned out.	F 467		
F 508 SS=D	483.75(k)(1) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure an x-ray that was ordered was performed for one (#79) of three sample residents with orders for had x-rays. The findings were: Review of nursing notes revealed resident #70 fell on 1/26/07 and sustained a non-displaced fracture of the pelvis. Review of the 1/26/07 physician's telephone orders for resident #79 revealed an order to repeat the pelvic x-ray in two weeks to evaluate the healing process. Review of the medical record revealed no evidence that the repeat x-ray was ever done. Interview with the	F 508	**F508 Radiology and Other Diagnostic Services** The Facility will provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility will be responsible for the timeliness and quality of the services. Resident #79 will have a follow up x-ray completed as ordered. A medical record audit will be completed to identify any other resident that may have experienced the same problem. Any problems noted will be corrected immediately. The Director of Nursing will review the 24-hour reports, all telephone orders from physicians and the CNA report sheets on a daily basis. Any follow up orders noted will be tracked through completion. The DON will compile a report monthly for the next 3 months and then quarterly for the QA Committee with the results of the audits, deficient practices and any discipline that was necessary. The DON is responsible for overall compliance.	5/31/07

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F 508	Continued From page 55 assistant director of nursing on 4/19/07 at 5:15 PM, confirmed the x-ray had not been done.	F 508		
F 513 SS=D	483.75(k)(2)(iv) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure x-ray results were located in the medical record for one (#68) of three sample residents who had x-rays taken. The findings were: Review of the medical record for resident #68 revealed an s/he was taken to the emergency room at the hospital for an x-ray of his/her leg on 2/2/07. Review of the entire medical record revealed the results of the x-ray was not in the chart. Interview with the director of nursing on 4/19/07 at 11 AM revealed she was unable to find the report in the medical record but had obtained in from the hospital.	F 513	**F513 Radiology and Other Diagnostic Services** The Facility will file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. Resident #68 will have the report of x-ray in his/her chart. A medical record audit will be completed to identify any other resident that may have experienced the same problem. Any problems noted will be corrected immediately. The nurse will assign follow up for any x-rays or labs on the MAR so that the reports can be tracked through completion. As a back up system Medical Records will review this area during routine chart audits to assure that results have been returned. The DON will compile a report monthly for the next 3 months and then quarterly for the QA Committee with the results of the audits, deficient practices and any discipline that was necessary. The DON is responsible for overall compliance.	5/31/07
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514		

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F 514	Continued From page 56 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure one (#25) of fourteen sample residents had medications accurately documented. The findings were: Review of the medical record for resident #25 revealed the April 2007 medication administration sheet which documented the resident's current medications. Further review revealed the resident received Forteo, a medication used to reduce bone loss, daily by injection. Further review showed six out of 18 days in April the resident had no documentation showing whether or not s/he had received the medication. Interview with the director of nursing on 4/18/07 at 1:45 PM revealed all medication ordered should be documented whether it was given or refused.	F 514	**F514 Clinical Services** The Facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. Resident #25's medication administration record will be complete showing that medications are administered as ordered. An audit of all MARs will be completed to identify any other deficient practices. Nurses will be in-serviced by May 22nd regarding documentation responsibilities. MARs will be reviewed on a weekly basis to assure that proper documentation has occurred. Any deficient practices will be corrected immediately. Any patterns of deficiency will be addressed with individuals. The DON will compile a report monthly for the next 3 months and then quarterly for the QA Committee with the results of the audits, deficient practices and any discipline that was necessary. The DON is responsible for overall compliance.	5/31/07