STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

(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 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, medical record review, and staff interview, the facility failed to ensure restraints were not utilized unless to treat a medical symptom and was the least restrictive device, for 1 of 1 sample resident (#56) who utilized a restraint. The findings were: Observation during the initial tour on 8/24/09 at 4:40 PM revealed resident #56 was ambulating in the hallway in an enclosed framed wheeled walker with a sling seat. Another observation on 8/24/09 at 6:40 PM showed the resident was ambulating in this walker. Certified nurse aides (CNAs) #2 and #3 opened the front gate of the walker and removed the resident from the sling seat and walker device. The resident did not assist in any way. The following concerns were identified: a. Medical record review revealed no physician's order for the use of the walker. The record showed a fax to the physician requesting an order for the walker on 8/13/09; however, there had been no response from the physician. b. There was no informed consent from the resident's family for the use of the walker. c. Review of the "Restraint/Merry Walker Assessment Record" dated 8/24/09 showed no medical symptom to justify the use of the walker. The reason for the use of the walker was documented as "mobility." The record showed no	F 221	F221 The facility will ensure that 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 will be accomplished by: 1) Use of the merry walker has been discontinued for resident #56. 2) A policy and procedure will be developed for use of restraints for residents in emergency situations only. This will include MD order and consent requirement. 3) An assessment tool will be developed and will be completed prior to use of an emergency restraint on any resident. 4) Unit coordinators to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09 9/28/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: x Anita Cox-Mills — TITLE: x Administrator — (X6) DATE: x 9/23/09

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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Wyoming Department of Health
NOV 09 2009
Office of Healthcare Licensing and Surveys

...MENT OF DEFICIENCIES ...D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 221	Continued From page 1 evidence an assessment was completed to determine that this walker was the least restrictive device. d. Futhermore, there lacked an assessment to determine the safety of the device. Refer to F-323 for details. e. During an interview on 8/26/09 at 3:45 PM, licensed practical nurse (LPN) #1 stated the resident could ambulate and transfer by himself/herself. The LPN stated the resident did not have the cognitive ability to remove the front gate of the walker independently. In addition, the LPN stated the resident used the walker "sometimes." Review of the current care plan (8/25/09) showed the walker was used "prn" [as needed]. However, there lacked criteria for staff to use to determine when the walker should be used. f. During an interview on 8/27/09 at 9 AM, the unit manager (for south unit) stated the walker was not a restraint because it was used for mobility. However, the unit manager did state that the walker prevented the resident from independently transferring to another chair or bed. g. On 8/27/09 at 10:30 AM, a restraint policy was requested from the administrator. The administrator stated the facility did not have a policy because they were restraint-free. During the interview, the administrator confirmed that the walker would prohibit the resident from transferring, because the resident could not independently release the front gate or get out of the sling seat.	~~F 221~~	F225 The facility will 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. This will be accomplished by: 1) State nurse aide registry was checked for employee #5. No findings of abuse, neglect or mistreatment of residents or misappropriation of resident property exists. 2) Employee #5 has resigned his/her position and is no longer employed at WRC. 3) Human Resources staff member will inquire into the State nurse aide registry for all newly hired certified nurse aides to ensure they have no findings of abuse, neglect or mistreatment noted. The inquiry will be in	9/28/09 9/28/09 9/28/09
F 225 SS=E	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	F 225		

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F 225	Continued From page 2 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations 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 review of personnel files and staff interview, the facility failed to ensure 1of 1 newly hired certified nurse aide (employee #5) did not	F 225	**F225** **The facility will 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.** **This will be accomplished by:** **1) State nurse aide registry was checked for employee #5. No findings of abuse, neglect or mistreatment of residents or misappropriation of resident property exists.** **2) Employee #5 has resigned his/her position and is no longer employed at WRC.** **3) Human Resources staff member will inquire into the State nurse aide registry for all newly hired certified nurse aides to ensure they have no findings of abuse, neglect or mistreatment noted. The inquiry will be in**	9/28/09 9/28/09 9/28/09

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F 225	Continued From page 2 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations 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 review of personnel files and staff interview, the facility failed to ensure 1of 1 newly hired certified nurse aide (employee #5) did not	F 225	F225 cont'd addition to conducting a criminal background check and attempting to obtain information from previous and/or current employers. 4) The State nurse aide registry was added to our "New Employee Checklist" to ensure the registry is checked for every newly hired certified nurse aide. 5) Policy regarding hiring new employees was revised to include verification of CNA licenses to be made through State abuse registry to ensure they are current and there are no findings of abuse, neglect, mistreatment or misappropriation of property. 6) Human Resource Manager to monitor for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09

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F 225	Continued From page 3 have a history of abuse. The findings were: Review of the personnel file for employee #5 showed no evidence the facility had inquired into the state nurse aide registry to ensure there had been no findings of abuse, neglect or mistreatment. Interview with a human resources staff member on 8/27/09 at 11:20 AM confirmed s/he had not checked the state nurse aide registry and was unaware it was required.	~~F 225~~	F278 The facility will ensure that Resident Assessment Protocols (RAPS) are signed and dated as completed prior to the VB2 date. This will be accomplished by:	
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1) The Unit Coordinators acknowledge that the date was not the same as VB2 date on full MDS. Date will not be changed to these existing RAPs now in place in the resident chart. 2) Each unit coordinator will verify that all RAPS for a resident requiring a full MDS in their assigned unit are completed by the VB2 date. RAPS will have the same date as the VB2 in place. RAPS will be given to medical records at the same time the signed MDS and care plan are given to them for placement in the resident's record.	9/28/09 9/28/09

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F 278	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a variety of Resident Assessment Protocols (RAPs) were signed and dated as completed prior to the VB2 date for 10 of 15 sample residents (#14, #15, #17, #27, #29, #35, #36, #49, #59, #60). The findings were: 1. According to the Centers For Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised March 2006, page 3-238, the VB2 is the "Date that the RN coordinating the RAP assessment process certifies that the RAPs have been completed...This date is considered the date of completion for the RAI [Resident Assessment Instruments] (i.e., the date used to determine compliance with Federal time frames for assessment and the date that drives future due dates for when the RAI needs to be completed)." 2. Review of the following RAIs revealed a variety of the RAPs were signed and dated as complete after the VB2 date: a. The 7/3/09 RAI for resident #14. b. The 6/19/09 RAI for resident #15. c. The 5/22/09 RAI for resident #17. d. The 5/8/09 RAI for resident #27. e. The 5/29/09 RAI for resident #29 f. The 6/5/09 RAI for resident #35. g. The 5/15/09 RAI for resident #36. h. The 6/11/09 RAI for resident #49. i. The 4/24/09 RAI for resident #59. j. The 5/15/09 RAI for resident #60.	F 278	F278 cont'd 3) At resident care conference, Section V - RAP Summary will be reviewed by the unit coordinators to ensure the RAPS, the signed MDS' and care plans from each department are complete and ready for submission to medical records. 4) A form will be used to document the month, a list of the residents with a full MDS, date of MDS, VB2 date and RAP number(s) being submitted to medical records. This information will be maintained by the MDS coordinator for Quality Improvement purposes. 5) MDS Coordinator to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09

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F 278	Continued From page 5 3. During an interview on 8/27/09 at 9 AM, the north and south unit managers stated the computer automatically put in the date at VB2. They stated they were sometimes still working on the RAPs after the VB2 date.	F 278		
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 the care plan was updated to reflect the current condition for 2 of 15 sample residents (#14, #17). The findings were: 1. Review of the 6/26/09 quarterly nutrition risk	F 280		

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F 280	Continued From page 6 assessment for resident #14 showed s/he had experienced a 10.1% weight loss in the past 180 days. Review of the 7/9/09 care plan showed the resident required constant oversight and encouragement, and needed to eat in the north dining room where residents who require assistance ate. The following concerns were identified: a. Observation of the noon meal on 8/26/09 revealed the resident was taken to the main dining room where residents who could eat independently ate, not the north dining room as indicated on the care plan. Interview with certified nurse aide #1 on 8/27/009 at 9:20 AM revealed no nursing staff were present in the main dining room, only dietary staff. b. Observation of the noon meal on 8/26/09 revealed the resident ate only one fourth of his/her main entree and nothing more. Continuous observation from 12 noon until 12:38 PM on 8/26/09 showed the resident received no assistance, cueing, or encouragement to eat his/her lunch. c. Interview with the administrator on 8/27/009 at 9:40 AM revealed it had been determined by the treatment team this resident became angry if staff or family tried to encourage or assist him/her to eat. Once the resident became angry, s/he refused to eat any more. She said the resident was moved to the independent dining room to see if s/he would be more comfortable and therefore eat more. The administrator said the care plan was incorrect and had not been updated to reflect this change in approach. 2. Review of the 8/26/09 care plan for resident #17 revealed s/he required foot pedals for leg support while in the wheelchair. Periodic	F 280	F280 The facility will ensure that care plans are updated to reflect the current condition of residents. This will be accomplished by: 1) The nutritional care plan for resident #14 has been updated to reflect current changes. 2) Care plan for resident #17 regarding use of foot pedals on the wheelchair has been updated to reflect current changes. 3) In-services regarding reviewing, updating, and correcting care plans have been held for nurses, certified nurse aides and the IDT members. 4) Dietary Manager and Unit Coordinators to audit randomly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09 9/28/09

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F 280	Continued From page 7 observations on 8/24/09 from 6:30 to 9:45 PM, on 8/25/09, 8/26/09, and 8/27/09 showed there were no foot pedals on the resident's wheelchair. Interview with registered nurse #2 on 8/27/09 at 9:50 AM revealed the foot pedals had been used after the resident had surgery in January 2009 and were no longer necessary. She further stated the care plan was not updated to reflect the improved condition of the resident.	~~F 280~~	F281 The facility will ensure that professional standards are followed related to MD's orders. This will be accomplished by:	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure professional standards were followed related to following physician's orders for 2 of 13 sample residents (#14, #35). The findings were: 1. Review of the 9/30/08 physician's orders for resident #14 showed an order for weights to be taken twice a week. Review of the weight flow sheets showed the resident's weight had been taken only once a week since 10/19/08. Interview with registered nurse (RN)#1 on 8/27/09 at 11 AM revealed she was unsure why the weights were not being taken twice weekly as ordered. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nurses must function under the direction of a licensed physician. 2. Review of a discharge instruction sheet and telephone orders dated 8/10/09 at 1:20 PM	F 281	1) MD was notified that resident #14 had not been weighed 2X/week as ordered. PA for the MD discontinued weights 2X/week and ordered weekly weights for the resident. 2) Resident #35 has been discharged. 3) In-services regarding the procedures of clarifying, communicating and documenting MD orders were held for nurses, certified nurse aides and medical records staff. 4) Unit Coordinators to audit monthly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09 9/28/09

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F 281	Continued From page 8 showed resident #35 had a colonoscopy and gastroscopy completed that day. The discharge instructions and telephone orders documented that the resident was not to take sedative drugs for 24 hours. Review of the medication administration record (MAR) showed the resident received Ativan 1 milligram (mg) on 8/10/09 at 3:30 PM. The resident also received Zyprexa 10 mg on 8/10/09 at bedtime. According to the Nurse's Drug Handbook, 2008 Edition, by Spratto and Woods, Ativan and Zyprexa each have sedation/drowsiness as the most common side effect. During an interview on 8/27/09 at 9 AM, the south unit manager stated nursing staff should have clarified the order with the physician prior to administering the Ativan and Zyprexa. According to "Legal & Professional Issues" by Wolters, Kluwer, Lippincott Williams & Wilkins, 2009, page 14: if a nurse is unsure of an order, she should clarify it with the physician prior to carrying it out.	~~F 281~~		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure a safe environment for residents in the facility activities room, the main hallway leading to the north unit, the resident's communal restroom in	F 323	F323 The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by:	

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F 323	Continued From page 9 the north unit and the north unit's patio hand rail. In addition, the facility failed to ensure a safety assessment was performed for 1 of 1 sample resident (#35) who had a walker restraint.The findings were: 1. Random observations during the survey revealed an unsecured electric range in the activities room. Four electric grills (cooking surfaces) were on the range top. All four grills were able to be turned on by turning their individual control knobs. Observations on 8/25/09 at 10:10 AM and then again on 8/26/09 at 3:30 PM revealed the door to the activities room was open and no staff were present to provide supervision. Interview with activities staff on 8/25/09 at 2:48 PM revealed the range was used by residents for activity of daily living purposes, and one resident occasionally cooked a meal on the range. Staff also stated the range could be turned on at any time. Interview with maintenance staff on 8/26/09 at 3:30 PM confirmed a wall switch or some other type of locking mechanism would prevent the range from being turned on by residents when no staff were present in the vicinity of the range. 2. Observation from 8/24/09 through 8/27/09 at random times revealed a large wooden splinter on the hallway hand rail outside the beauty shop. The splinter had been taped over. Interview with maintenance staff on 8/26/09 at 3:30 PM confirmed the tape was a temporary measure to prevent injury to someone who might bump up against the rail. 3. Observation from 8/24/09 through 8/27/09 at random times revealed a wobbly toilet grab bar in the resident's shower room on the north unit.	F 323	F323 cont'd 1) A switch will be installed to prevent the range from being turned on by unsupervised residents. 2) Hand rail by the beauty shop has been removed, repaired and reattached. 3) The toilet grab bar in the resident's shower room on the north unit was tightened. 4) Welding has been done to the base plate on metal hand rails surrounding the north patio to stabilize them. 1-4) Environmental Services Manager to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09 9/28/09 9/28/09

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	535021	A. BUILDING _____ B. WING _____	08/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 US HWY 20 SOUTH BASIN, WY 82410

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F 323	Continued From page 10 Interview with maintenance staff on 8/26/09 at 3:30 PM confirmed the bar was unstable and should be secured. 4. Observation from 8/24/09 through 8/27/09 at random times revealed the metal hand rails surrounding the north patio were loose and wobbly. Interview with maintenance staff on 8/26/09 at 3:48 PM confirmed the rails were unstable. 5. Observation on 8/24/09 at 4:40 PM and again at 6:40 PM revealed resident #56 was ambulating in an enclosed framed wheeled walker with a sling seat. Review of nursing notes showed on 8/18/09 at 6 AM the resident was found on the floor. The walker was documented to be on its side, and the resident was inside of it. The following concerns were identified: a. Review of the "Walker/Restraint Assessment Record" dated 8/24/09 showed that on 8/18/09 the resident had a fall. However, under "Conclusions From Assessment," it was documented that there were no risks associated with the use of the device. There lacked evidence a comprehensive assessment was done to determine the safety of the device. b. During an interview on 8/27/09 at 9 AM, the south unit manager confirmed there was no other safety assessment.	F 323	F323 cont'd 5a) Use of the merry walker has been discontinued for resident #56. 5b) A safety assessment will be completed by physical therapy prior to the use of any mobility device for any resident. 5c) Staff will be in-serviced on the requirement for physical therapy to evaluate all residents before a mobility device is initiated for any resident. 5d) Unit coordinators to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations	9/28/09 9/28/09 9/28/09 9/28/09
F 329 SS=D	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	~~F 329~~		

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F 329	Continued From page 11 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary drugs for 2 of 15 sample residents (#35, #56). The findings were: 1. Review of physician's orders showed resident #35 was ordered Trazadone (antidepressant) 50 milligrams (mg) as needed at bedtime for insomnia. Review of the August 2009 medication administration record (MAR) revealed the resident had received the medication thirteen times from 8/1/09 through 8/25/09. Review of the medical record showed no evidence a comprehensive sleep assessment was ever completed to determine potential causative factors for the insomnia. There was no evidence that non-pharmacological interventions had been	F 329	F329 The facility will ensure that each resident's drug regimen will be free from unnecessary drugs. This will be accomplished by: 1) Resident #35 has been discharged. 2) Ambien for resident #56 was discontinued per MD's order. 3) A comprehensive sleep assessment will be done on all residents prior to use of medications for sleep. 4) As part of the admission procedure, a comprehensive sleep assessment will be conducted for all new residents admitted with orders for sleep medication(s). 5) A standard operating procedure regarding	9/28/09 9/28/09 9/28/09 9/28/09 9/28/09

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F 329	Continued From page 12 attempted to address this resident's insomnia. 2. Review of physician's orders showed resident #56 was ordered Ambien (sedative-hypnotic), 10 mg at bedtime for sleep. Review of the August 2009 MAR showed the resident received the medication as ordered. Further medical record review showed no comprehensive sleep assessment was ever done to determine potential causative factors for the insomnia. In addition, there lacked evidence any non-pharmacological interventions had been attempted. 3. During an interview on 8/27/09 at 9 AM, the north and south unit managers verified there had been no comprehensive sleep assessments done.	F 329	F329 cont'd comprehensive sleep assessments, the use of non-pharmacological interventions and the use of sleep medications will be adopted. 6) Unit Coordinators to audit for compliance and report results quarterly to the Pharmacy Review Committee and the Quality Improvement Committee for review and recommendations.	9/28/09
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a cooking appliance was maintained in a safe manner. In addition, the facility failed to ensure a baseboard heater cover was securely attached in one of three soiled utility closets. The findings were: Random observation during the survey revealed six tin can lids on the kitchen range. Each lid measured 6-inches in diameter. Interview with the maintenance manager and the kitchen manager on 8/25/09 at 10:48 AM revealed the lids were	~~F 465~~		

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F 465	Continued From page 13 from discarded tin cans and were placed over the range pilot lights to prevent them from going out when the overhead (ceiling) vent fans were in operation. The maintenance manager explained the range was "old and did not have thermocouples to turn the gas off in the event the pilot lights went out". The kitchen manager stated that when the pilot lights did go out, she could smell gas leaking into the kitchen. She also stated she kept a butane lighter handy to start the pilot lights again if they were to go out. Observation on 8/25/09 at 3:48 PM revealed the baseboard heater in the soiled utility room in the "A" pod of the south unit had a missing cover plate. In addition, another cover plate was displaced exposing ankle high sharp metallic heating fins. Interview with the maintenance manager at the time revealed the exposed metal edges represented an accident hazard to staff.	F 465	F465 The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This will be accomplished by: 1) Kitchen stove will be replaced.	9/28/09
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory 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 staff interview and medical record review, the facility failed to obtain timely and accurate laboratory services for 2 of 13 sample residents (#14, #29). The findings were: 1. Review of the diagnosis report for resident #14 showed s/he was admitted with diagnoses including diabetes. Review of the signed August 2009 recapitulation of physician's orders revealed	~~F 502~~	2) The cover plates on the baseboard heater in the soiled utility room in the "A" pod of the south unit were reattached. 3) Environmental Services Manager to audit for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09

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F 465	Continued From page 13 from discarded tin cans and were placed over the range pilot lights to prevent them from going out when the overhead (ceiling) vent fans were in operation. The maintenance manager explained the range was "old and did not have thermocouples to turn the gas off in the event the pilot lights went out". The kitchen manager stated that when the pilot lights did go out, she could smell gas leaking into the kitchen. She also stated she kept a butane lighter handy to start the pilot lights again if they were to go out. Observation on 8/25/09 at 3:48 PM revealed the baseboard heater in the soiled utility room in the "A" pod of the south unit had a missing cover plate. In addition, another cover plate was displaced exposing ankle-high sharp metallic heating fins. Interview with the maintenance manager at the time revealed the exposed metal edges represented an accident hazard to staff.	~~F 465~~	F502 The facility will provide or obtain laboratory services to meet the needs of its residents. The facility will be responsible for the quality and the timeliness of the services. This will be accomplished by: 1) MD was notified of lab draws not being completed as ordered. Received new orders for QID glucometer checks from PA.	9/28/09
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory 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 staff interview and medical record review, the facility failed to obtain timely and accurate laboratory services for 2 of 13 sample residents (#14, #29). The findings were: 1. Review of the diagnosis report for resident #14 showed s/he was admitted with diagnoses including diabetes. Review of the signed August 2009 recapitulation of physician's orders revealed	F 502	2) Lab requisition was immediately implemented and completed for resident #29. 3) Change in procedures implemented to improve receiving of orders for lab draws and receiving, documenting and filing of lab results. 4) In-services regarding the procedures of clarifying, communicating and documenting	9/28/09 9/28/09 9/28/09

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F 502	Continued From page 14 an order dated 12/21/06 for a fasting blood sugar draw two times per month. Review of the laboratory reports revealed a fasting blood sugar draw was not performed twice monthly as ordered. The laboratory draws were only performed on 10/15/08, 11/24/08, 12/10/08, 3/18/09, 5/20/09, and 8/12/09. Interview with registered nurse (RN) #1 on 8/27/09 at 11 AM revealed laboratory draws were not performed twice monthly due to confusion regarding the order. 2. Review of the signed July 2009 recpitulation of physician's orders for resident #29 showed an order dated 4/22/08 for a lipid profile every six months. Review of the laboratory reports revealed a lipid profile was performed on 11/6/08, but the test due at the next six month interval (May 2009) still had not been done as of 8/27/09. Interview with RN #1 on 8/27/09 at 11 AM revealed the reason the test was not performed in May as ordered was due to a transcription error.	F 502	F502 cont'd MD orders; and receiving of orders for lab draws, and receiving, documenting and filing of lab results were held for nurses, certified nurse aides and medical records staff. 5) Medical records will complete a monthly lab audit for outstanding labs.	9/28/09
F 507 SS=D	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain the results of a follow-up laboratory test analysis for 1 of 13 sample residents (#14). The findings were: Review of the 5/27/09 physician's orders for resident #14 showed an order for Bactrim D.S. to	~~F 507~~	6) Unit Coordinators to audit quarterly compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09

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F 502	Continued From page 14 an order dated 12/21/06 for a fasting blood sugar draw two times per month. Review of the laboratory reports revealed a fasting blood sugar draw was not performed twice monthly as ordered. The laboratory draws were only performed on 10/15/08, 11/24/08, 12/10/08, 3/18/09, 5/20/09, and 8/12/09. Interview with registered nurse (RN) #1 on 8/27/09 at 11 AM revealed laboratory draws were not performed twice monthly due to confusion regarding the order. 2. Review of the signed July 2009 recpitulation of physician's orders for resident #29 showed an order dated 4/22/08 for a lipid profile every six months. Review of the laboratory reports revealed a lipid profile was performed on 11/6/08, but the test due at the next six month interval (May 2009) still had not been done as of 8/27/09. Interview with RN #1 on 8/27/09 at 11 AM revealed the reason the test was not performed in May as ordered was due to a transcription error.	~~F 502~~	F507	
F 507 SS=D	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain the results of a follow-up laboratory test analysis for 1 of 13 sample residents (#14). The findings were: Review of the 5/27/09 physician's orders for resident #14 showed an order for Bactrim D.S. to	F 507	The facility will file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This will be accomplished by: 1) Obtained a copy of the 6/9/09 lab results for resident #14 and placed them in the resident's medical record.	9/28/09

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F 507	Continued From page 15 be taken seven days for a urinary tract infection. Review of the 6/2/09 physician's orders showed an order for a follow-up UA (urinalysis) in one week. Review of the medical record revealed there were no results to the follow-up UA ordered. Interview with registered nurse #1 on 8/27/09 at 11 AM revealed the UA was performed on 6/9/09 but the results were not in the medical record. The results were obtained from the laboratory on 8/27/09.	F 507	507 cont'd 2) Change in procedures implemented to improve receiving of orders for lab draws and receiving, documenting and filing of lab results. 3) In-service held for nurses and medical records regarding procedures for receiving of orders for lab draws and receiving, documenting and filing of lab results. 4) Unit Coordinators to audit quarterly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	9/28/09 9/28/09 9/28/09