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

PRINTED: 11/05/2008
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
	53A002	A. BUILDING _____ B. WING _____	10/23/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIE HOLT CARE CENTER	497 W LOTT BUFFALO, WY 82834

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F 226 SS=E	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 facility investigation reports, policy and procedure review, and staff interview, the facility failed to submit the results of abuse investigations to the survey and certification agency within 5 working days in accordance with facility policy for three of five allegations reviewed. The findings were: Review of the facility's policy "Abuse" (revised 6/24/03) revealed "...The results of the investigation shall be reported to the administrator and other officials, including the State survey and certification agency, within five working days." Review of facility investigation reports revealed the following concerns: a. Review of an allegation of abuse to resident #37 dated 3/29/08 showed the results of the investigation were not submitted to the survey and certification agency until 4/10/08 (nine working days). b. Review of an allegation of abuse to resident #11 dated 1/25/08 revealed the results of the investigation were not reported to the survey and certification agency until 2/14/08 (14 working days). c. Review of an allegation of abuse to resident #12 dated 8/17/08 revealed the results of the investigation were not submitted to the survey and certification agency until 8/25/08 (six working days).	F 226	F226: The facility will ensure that written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property will be implemented, including submitting the results of abuse investigations to the survey and certification agency within five working days. This will be accomplished by: A) Time frame for those residents found to have been affected cannot be changed. B) The DON is involved in all reported allegations and will keep a log of when incidents were reported and on what date a follow up is required. C) The DON will check this log daily and keep responses timely. D) A performance improvement tool will be implemented to ensure follow up responses occur within five working days. This information will be reported monthly to the Performance Improvement (PI) Committee.	12-7-2008

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

Rett L. Wall — ADMINISTRATOR — 11/13/08

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.

Wyoming Dept of Health

NOV 13 2008

This POC accepted with agreed to changes by Brenda Evans and Greg Walker on 11/24/08.

Office of Healthcare Licensing and Surveys

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F 226	Continued From page 1 During an interview on 10/22/08 at 2:20 PM, the director of nursing (DON) confirmed the results were submitted late. The DON stated she was aware the results were supposed to be submitted within five working days.	F 226	F323: The facility will ensure that the resident environment remains as free of accidental hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.	
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 review of incident reports and medical records, the facility failed to provide a safe and secure environment for residents. Specifically, the facility made no provision for staff to gain additional assistance when needed in the secure care unit (SCU). In addition, a box cutter knife was stored in a location accessible to residents in one of two clean utility rooms, and scalpel blades were left within reach of residents after a physician made rounds. The findings were: 1. Interview with certified nurse aide (CNA) #1 on 10/22/08 at 10:45 AM revealed the SCU was only staffed with one CNA. The CNA stated the telephone in the bathroom next to the nurses' station had been pulled from the wall some time ago, and maintenance was unable to install another one. When asked how she gained additional assistance if it was needed, the CNA	F 323	This will be accomplished by: A) -The facility will make provisions for staff to gain additional assistance when needed in the Special Care Unit by providing a contact device for the SCU CNA to communicate directly and immediately with the Supervising Nurse. -The box cutter was removed from the clean utility room and locked in the medication room. This will not be returned until the maintenance dept. equips the clean utility room with a locking door. -Sharp medical supplies have been removed from the physician's rounds cart. They are kept locked in the medication room and will be obtained by nursing staff as needed and always placed out of reach of residents.	

This POC accepted with agreed to changes by Brenda Bonn and Terry Mosher on 11/24/08.

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F 323	Continued From page 2 stated there were call lights in every room and that a land line telephone was located at the nurses' station and in the tub room. The CNA further stated she carried her own personal cell phone for emergencies, and that she had used it six times to summon help. CNA #1 worked eight hour shifts; the CNA coming on duty did not carry a personal cell phone. The following safety issues were identified: a. Observation on 10/22/08 at 11:30 AM revealed CNA #1 assisted resident #20 to the bathroom. While the CNA was unavailable, resident #7 began yelling, "Come lay me down." An unidentified resident told resident #7, "You can get up and walk." Resident #7 then tried to get a visitor to assist him/her to bed. Finally, several residents told Resident #7 to be quiet. One resident told resident #7, "If you have something to do, get up and do it!" Medical record review showed that on 10/5/08 staff documented the resident would call out until other residents became upset and told him/her to "shut up." The documentation also revealed this resident would calm down if someone provided continuous one to one attention. b. On 10/23/08 at 9:18 AM, CNA #1 stated she was "trapped" in the bathroom by the nurses' station with resident #20 for approximately 25 minutes. The resident became combative and the CNA was unable to reach her phone or the call light as she was holding the resident's arms. The CNA stated she could not let the resident out of the bathroom as there were "two helpless residents" in the kitchen (near the nurses' station), and she did not want them to be injured. The CNA stated she completed an incident report. Review of that report showed the incident occurred on 9/17/08; it was signed by the DON. The report also indicated a previous incident with	F 323	B) -All CNAs working in the SCU will be able to summon help as needed using the communication device, including when help is needed for resident #7 -All staff on duty are responsible to help ensure that all sharp objects are kept out of residents' reach. The charge nurse is to be informed if anyone is seen leaving dangerous objects where residents can get them so immediate in-servicing and corrective action can be taken. C) -AHCC nurses and CNAs will be oriented to the SCU communication device during November, 2008. -During November 2008, DON will review with nurses and CNAs the need to be vigilant in identifying and removing hazardous objects to locked areas to prevent resident accessibility.	

This POC accepted with agreed to changes by Brenda Sorn and Tony Wadda on 11/24/08.

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F 323	Continued From page 3 this resident occurred on 9/10/08. Furthermore, in the 9/17/08 report, the CNA documented she felt the resident "was capable of hurting someone." c. On 10/22/08 at 10:45 AM the surveyor asked about the response to the call lights by other staff. The CNA (#1) stated that instead of responding immediately, staff outside the unit would call and ask her if she knew a call light was on. Since most of the residents in the SCU cannot use the call lights, this response delayed arrival of needed assistance. d. On 10/22/08 at 2:40 PM CNA #1 stated she needed assistance one day while a picnic was being held outside the facility. When she used her personal phone to call for assistance, it was not answered as all staff were outside. 2. Observation on three consecutive days (10/21/08 at 4:44 PM, 10/22/08 at 3:11 PM and again on 10/23/08 at 10:48 AM) revealed a box cutter knife hanging from a string in the clean utility room in the east hallway. The clean utility room did not have a lock on the door. Interview with registered nurse (RN) #2 on 10/23/08 at 10:48 AM revealed she was unaware the cutter was there. She verified the knife could be a safety hazard to residents. 3. Observation on 10/22/08 between 3:44 PM and 5:11 PM revealed a cart containing medical records in the 300 hall. Placed on top of the cart was a box of medical supplies including a box of approximately 40 stainless steel scalpel blades, size #15. Observation at that time also revealed more than one resident was observed in the vicinity of the cart. Interview with RN #3 on 10/22/08 at 5:11 PM revealed the box of supplies	F 323	D) A performance improvement tool will be implemented to evaluate the ability of the SCU CNA to gain additional assistance when needed and to monitor that hazardous items are properly stored. This information will be reported monthly to the Performance Improvement Committee.	12-7-2008

This POC accepted with agreed to changes by Brenda Bern and Tony Madden on 11/24/08.

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F 323	Continued From page 4 had been left on the cart after a physician had seen residents earlier in the afternoon. She acknowledged the blades were a potential safety hazard to residents.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician acted upon reported irregularities for 1 (#34) of 11 sample residents. The findings were: According to the physician's orders, resident #34 was started on Ambien (a hypnotic) 5 milligrams on 3/5/08. Review of the medication administration records from March 2008 through October 21, 2008 showed the medication was administered as ordered. Review of the pharmacist's monthly medication regimen reviews (MRRs) showed that in April 2008 the pharmacist documented that Ambien needed to be reviewed in May and included a request to "please verify need." The documentation of the May MRR was a ditto mark below April. In September 2008, the pharmacist wrote "Need reviewed by MD." Review of the physician's documentation from	F 428	F428 The facility will ensure that the drug regimen of each resident is reviewed at least once monthly by a licensed pharmacist, who reports any irregularities to the attending physician and DON, and these reports are acted upon. A) The physician for resident #34 documented justification for continuous use of Ambien in this residents medical record, since the survey. B) A drug regimen review is conducted monthly for all residents. The pharmacist will report any identified irregularities on the MRR to the physician personally and to the DON via e-mail. The pharmacist will update the review form to include a "date resolved" column. C) The pharmacist will discuss this deficiency and how it will be addressed at a Medical Staff Meeting in November.	

This POC accepted with agreed to changes by Brenda Bonn and Terry Trubbey on 11/24/08.

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F 428	Continued From page 5 May through October 21, 2008 showed no response to the requests. Interview with the pharmacist on 10/23/08 at 8:15 AM revealed he reported irregularities directly to each physician as well as documenting them in the MRR. He stated the physicians wrote their responses in their notes, and he confirmed this specific irregularity lacked a physician's response.	F 428	D) The pharmacist will develop a performance improvement tool to evaluate whether irregularities are being reported and acted upon as required. This information will be reported monthly to the Performance Improvement Committee.	
F 465 SS=D	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, facility policy review, and staff interview, the facility failed to provide a safe environment for kitchen staff. The findings were: Observation of the kitchen walk-in freezer on three consecutive days (10/21/08 at 3:58 PM, 10/22/08 at 3:30 PM and again on 10/23/08 at 9:11 AM) revealed 7 ice cubes on the floor. Interview with the kitchen manager on 10/23/08 at 11:10 AM revealed the ice cubes on the floor constituted a fall hazard for staff. In addition, the manager stated removal of the ice cubes from the floor was a specific task assigned to kitchen staff. Observation throughout the survey revealed a sign posted on the pantry refrigerator stating: "Please pick up all ice cubes off the floor." Interview with the administrator on 10/23/08 at 1:30 PM revealed a staff person recently fell and injured her hand due to ice on the floor and the facility considers "ice on the floor a serious safety hazard."	F 465	F465 The facility will ensure that a safe environment is provided for kitchen staff. This will be accomplished by: A) The ice cubes found at the time of survey were removed from the floor of the walk-in freezer. B) The Dietary Manager (DM) will observe that kitchen staff remove ice cubes from the floor of this area. If this is not done adequately, immediate in-servicing and corrective action will be taken with the individual.	12-7-2008

This POC accepted with agreed to changes by Brenda Sarvis and Tony Mathey on 11/24/08.

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		F 465	C) The DM provided education to all dietary staff on the importance of removing ice from the floor to ensure safety for all. D) A performance improvement tool will be implemented to ensure that ice cubes are not left on the floor. This information will be reported monthly to the PI Committee.	12-7-2008

This POC accepted with agreed to changes by Brenda Dorny and Tony Trudden on 11/24/08.

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