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

PRINTED: 12/01/2009
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 ____	11/19/2009

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

(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 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 policy and procedures review, staff interview, and review of personnel records and abuse investigation documentation, the facility failed to ensure the state survey agency (SSA)was notified immediately of allegations of abuse in accordance with written policies for 1 of 4 allegations reviewed. In addition, the facility failed to check with the certified nurse aide (CNA) registry for Wyoming prior to employment for 1 of 1 newly hired CNA. The findings were: 1. Review of the facility's "Abuse" policy and procedures (revised 6/24/03) showed "...The DON shall report all alleged cases of abuse to the Department of Health immediately and to other officials in accordance with State law." In addition, "...Potential employees are screened for a history of abuse, neglect, or mistreatment of residents. This includes attempting to obtain information from previous and/or current employers, and checking with the appropriate licensing boards and registries." The following concerns were identified: a. Review of facility abuse investigation documentation revealed an allegation of abuse was reported on 7/10/09, involving resident #41. However, the allegation was not reported to the SSA until 7/13/09. During an interview on 11/18/09 at 2:34 PM, the director of nursing (DON) stated she was aware allegations should	F 226	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 notifying the state survey agency immediately of allegations of abuse and checking the WY CNA registry prior to employment when applicable. This will be accomplished by: A)Time frame for resident found to have been affected cannot be changed. WY CNA registry was checked for CNA affected. B)DON will report allegations within 24 hours of incident when on duty and will educate all nurses re notification on weekends or other times DON is unavailable. DON is involved in all hiring of CNAs and will check the WY CNA registry prior to employment when applicable. C)DON will educate all nurses re the requirement of immediate notification of SSA for abuse type allegations, information that must be included in notification, and the procedure for faxing this data to SSA and other appropriate parties. DON will keep a log of potential new-hire CNA applicants showing when the WY CNA registry was checked and refer to it prior to hiring. D)A performance improvement tool will be implemented to ensure allegations are reported within 24 hours and the WY CNA registry is checked prior to hiring. This information will be reported monthly to the Performance Improvement (PI) Committee.	1/03/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 12/8/09

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.

RECEIVED
DEC 14 2009
Wyoming Office of Healthcare Licensing and Surveys

This POC accepted on 12/21/09 during a phone call to Sandy Ward, Administrator, Brenda Stang, [illegible] 12/21/09

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F 226	Continued From page 1 be reported within 24 hours. She further stated this allegation was reported during a weekend, and she was not aware she could fax the incident report to the SSA over a weekend. b. Review of personnel records showed certified nurse aide (CNA) #1 was hired on 8/31/09. There lacked evidence in the personnel file that the Wyoming CNA registry was checked for this employee. During an interview on 11/18/09 at 2:34 PM, the DON confirmed the Wyoming CNA registry was not checked for this employee.	F 226		
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, medical record review, and staff interview, the facility failed to ensure 1 of 3 doors in the secure care unit (SCU) was secure to prevent elopement during a random observation. The census in the SCU was 6. In addition, the facility failed to provide adequate supervision to prevent elopement for 1 of 1 sample resident (#3) in the SCU, and failed to complete a safety assessment for 1 of 1 sample resident (#21) with a restraint. The findings were: 1. Observation on 11/16/09 at 4:48 PM revealed the special care unit entrance/exit door to the outside was not completely closed. As a result,	F 323	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. This will be accomplished by: A)The door in the SCU that was not functioning properly was repaired by maintenance. The code was changed since sample resident #3 eloped. A restraint safety assessment will be completed for resident #21. B)DON will randomly check all 3 SCU doors to ensure that they are latching and locking appropriately; if not, maintenance will be notified immediately. DON will in-service staff on the need to report safety information immediately, such as a resident figuring out the SCU code. Nurse Team Leaders will complete safety assessments prior to implementing restraints.	

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F 323	Continued From page 2 the electronic door alarm circuit was inactive. Therefore, anyone could enter or exit through the door without activating the alarm. Interview with certified nurse aide (CNA) #3 working in the unit at the time revealed it was approximately 30 minutes since the door was last used. Additional observation at the time revealed a sign attached to the door stating "Please make sure the door clicks". Observation of the door closure mechanism and interview with the director of nursing (DON) on 11/17/09 at 8:15 AM revealed the door closure mechanism was not working properly and the door did not close completely when someone entered or exited through the door. 2. Review of the incident/accident log revealed resident #3 eloped from the SCU on 8/20/09. Review of the medical record showed on 8/20/09 at 1:15 PM the resident was missing, and was later found outside in front of the building. The documentation showed maintenance was notified to change the code to the door as this was how the resident eloped. It was documented that the previous day CNA stated the resident knew the code to the door. There was no evidence the CNA who worked the previous day, and who was aware the resident knew the code, had reported the resident knew the code, or requested the code be changed. During an interview on 11/17/09 at 3:21 PM the DON and registered nurse (RN) #1 stated when they investigated the elopement, they discovered the CNA working the previous day was aware the resident knew the code, but did not report it.	F 323	C)DON will in-service nurses and CNAs on the need to be aware of the potential for a SCU door to fail and instruct them to check the doors periodically when they work in that area – especially when the know someone has entered or exited. DON will in-service CNAs on the need to report safety information to their supervisor immediately, and in-service nurses on the importance of notifying maintenance immediately in a case such as a code needing to be changed to ensure a resident's safety. DON will in-service Team Leaders on need to do safety assessments prior to implementation of restraints. Nurses and CNAs will be reminded that they are not to implement restraints unless the Team Leader directs them to do so. D)Performance improvement tools will be implemented to ensure that SCU doors are functioning properly, staff reports and takes appropriate action if a SCU resident learns the exit code and restraint assessments are completed prior to implementation. This information will be reported monthly to the PI Committee.	1/03/10

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F 323	Continued From page 3 3. Observation on 11/18/09 at 9:30 AM showed resident #21 in a wheelchair with a secured seatbelt. At that time the resident was not able to unlatch the seatbelt when asked to do so by the surveyor and CNA #2. Review of the physician's orders showed the resident had an 8/3/09 order for a seatbelt when in a wheelchair to prevent falls. Review of a 8/3/09 note written by the DON showed the seatbelt needed to be assessed for safety prior to implementation. Interview with the DON on 11/18/09 at 1:45 PM showed she considered the resident's seatbelt to be a restraint. She further stated the resident was not assessed for safety concerning use of the seatbelt.	F 323		
F 371 SS=D	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the 2009 Food Safety Code, the facility failed to ensure cooking equipment was maintained in clean manner. The findings were: Observation on 11/16/09 at 5:48 PM revealed a thick accumulation of baked-on food residue on the bottom and sides inside of the oven in the	F 371	The facility will ensure that food is procured from satisfactory sources and stored, prepared, distributed and served under sanitary conditions. This will be accomplished by: A)Activities staff cleaned the oven in the facility pantry. B)The Activities Director will check the oven periodically; if it is not clean, she will direct her staff to clean it before it is next used. C)The Activities Director will in-service her staff on checking the oven before and after each use for any fresh spills, which are to be cleaned immediately. The Activities staff will thoroughly clean the oven every three months, or sooner if needed. A record will be kept of the cleanliness before and after use and the scheduled cleanings. D)A Performance Improvement tool will be implemented to ensure that the oven is kept clean. This information will be reported monthly to the PI Committee.	1/03/10

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F 371	Continued From page 4 facility pantry. Interview with the activities director on 11/17/09 at 1:15 PM revealed the oven was used primarily by staff and was occasionally used to bake food items for resident consumption. Interview also revealed the oven was used as a scheduled activity the previous day to make "monkey bread," which the residents consumed. The activities director stated she was going to clean the oven the previous week but did not work that week. According to Food Code 2009, U.S. Public Health Service, 4-601.11, Equipment, Nonfood-Contact Surfaces. (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	The facility will ensure that drugs used in the facility are labeled with all the necessary information, including the expiration date. This will be accomplished by: A)The Prescription Shop (outside pharmacy) will include expiration dates on the medication cassettes for residents #6, 9, and 35. Resident #29 has passed away. B)The Prescription Shop will include expiration dates on the medication cassettes for any other residents it provides services for in the future. C)DON will advise nurses of need for expiration dates on cassettes. A monitor will be placed in the medication room as a reminder for medication nurses to check that cassettes coming from this outside pharmacy include expiration dates. If cassettes do not have this information, they will be returned to the pharmacy for correction. D)A performance improvement tool will be implemented to ensure that medication cassettes include expiration dates. This information will be reported monthly to the PI committee.	1/03/10

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F 431	Continued From page 5 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medication labels included expiration dates for 4 of 39 residents (#6, #9, #29, #35) in the facility. The findings were: Observation on 11/18/09 at 8:30 AM of medications stored on two medication carts and one medication room showed four residents (#6, #9, #29, #35) used an outside pharmacy for their medications. Further observation showed the containers for each medication supplied by the outside pharmacy had no expiration dates on the label or container; therefore, no determination could be made if the medications were outdated. Interview with licensed practical nurse (LPN) #1 on 11/18/09 at 8:30 AM revealed she could not find expiration dates for the four residents' (#6, #9, #29, #35) medications supplied by an outside pharmacy. A phone interview on 11/18/09 at 10:10 AM with the outside pharmacy tech (#1) responsible for medications sent to the facility revealed they did not put expiration dates on medication labels or containers.	F 431		

12/2/09