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

PRINTED: 08/21/2014
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
	535022	B. WING	C 08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs- Activities of daily living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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.	F 280	F 280 Correction for cited residents: Resident #14 Resident's condition was reassessed on 08/07/14. Assessment revealed no need for floor mats or alarms. Side rail assessment completed on 08/07/14. Low air loss mattress with side rails are in place due to manufacturer's recommendation. Care plan revised to reflect current needs 08/7/14. Resident #13 Care plan was updated on 08/07/14 to reflect use of bed cane for bed mobility. Identification of other residents will occur by: All residents have the right to have individualized plans of care to meet their unique needs. Systemic Corrective Action: 1.Develop and implement weekly nursing rounds to include a review of each resident's plan of care. 2.Conduct staff education to all clinical staff (Activities, CNA, Nursing, Therapy) related to review of individualized care plans, mobility devices and side rail usage with evidence of competency. 3.Revise printed report on closet care plans to reflect date.	~~08/7/14~~ ~~08/07/14~~ ~~08/31/14~~ ~~11/07/14~~ 9/26/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 8/28/14

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.

Changes made per phone call with Donni Belden, NHA on 8/29/14 @ 12:32 pm. DOC = 9/26/14. POC accepted. Janice Colin, OSIC

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the care plans were revised to reflect the current needs for 2 of 20 sample residents (#13, #14). The findings were: 1. Observation on 8/5/14 at 9:16 AM showed resident #14 used full length side rails while in bed and had an air mattress. There was no fall mat on the floor next to the bed or alarms. An interview with CNA #1 on 8/6/14 at 9:30 AM revealed the resident was unable to turn in bed independently, and staff turned/repositioned the resident every 2 hours. Review of the undated care plan for safety showed the resident was to have a floor mat placed at the bedside. Further, a tabs alarm was to be used to alert staff if the resident attempted to get up from the bed without assistance. The care plan also indicated side rails were initiated due to the use of an air mattress as recommended by the manufacturer. During an interview with the DON on 8/7/14 at 8:13 AM, she revealed the resident no longer attempted to get up from the bed without assistance. The alarms and floor mat had been removed due to his/her change in status. Further, she acknowledged the the care plan needed to be updated to reflect these changes. 2. Random observations on 8/5/14 through 8/6/14 showed resident #13 had a bar attached to his/her bed. Review of the undated care plan for physical mobility failed to show the resident had any type of device attached to his/her bed. The care plan only showed the resident used a cane or wheelchair for mobility. During an interview with the DON on 8/7/14, she indicated the	F 280	F 280 cont. Outcome: 95% of care plans will reflect mobility device usage and side rail usage DON or designee will collect data from nurse rounding reports monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	~~11/07/14~~ 9/26/14

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F 280	Continued From page 2 resident used the bar for mobility and repositioning while in bed. Further, she acknowledged the use of the device needed to be updated on the care plan.	F 280	F 281 Correction for cited residents: Resident 103 PT staff education completed and wound vac documentation completed reflecting number of sponges and dressing change. Nursing staff education regarding troubleshooting wound vacuum and resources.	~~08/31/14~~ 9/26/14
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed standards for clinical practice for 1 non-sample resident (#103) who utilized negative pressure wound therapy (wound vacuum) for wound healing. In addition, the facility failed to ensure orders were followed for 1 of 20 sample residents (#100). The findings were: 1. Review of the medical record showed resident #103 was re-admitted to the facility on 6/24/14 with diagnoses including aftercare/healing of a traumatic fracture, wound infection, and right hip hematoma (blood filled bruise). Review of a hospital discharge summary dated 6/21/14 revealed the resident developed an infection and hematoma in his/her right hip incision that required a surgical procedure to open and drain the wound and wound. Wound vacuum therapy was initiated at that time, and the resident was re-admitted to the facility with the wound vacuum in use. Review of an undated care plan identified the resident as having impaired skin integrity. Interventions included monitoring the incision and use of the wound vacuum to be changed and	F 281	Resident 100 PT screen post fall completed 08/28/14 Identification of other residents will occur by: 1.All residents have the potential to be affected by incomplete documentation and training related to wound vacuum devices 2.All residents have the potential to be affected by delayed or incomplete orders and implementation of policies Systemic Corrective Action: 1.Wound Vac documentation will be revised and implemented in the EMR to include sponge counts, actions and functional status of wound vac.. 2.Nursing and therapy staff education regarding documentation and care of the wound vac with demonstrated competency. 3.Two LTC RN's will be scheduled to attend Wound certification training in 2014. 4.Review and revise wound care policy to include wound vac trouble shooting algorithm.	~~08/31/14~~ ~~11/07/14~~

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F 281	Continued From page 3 managed by physical therapy (PT). The following concerns were identified: a. Observations on 8/4/14 at 4 PM and 8/6/14 at 4:10 PM revealed the resident had a wound vacuum in place. Observation with physical therapy assistant (PTA) #1 on 8/6/14 at 4:10 PM also showed the resident's wound vacuum was functioning at 125 mm/hg (millimeters mercury) continuous suction and the number of dressing pieces in the wound bed were not indicated. Interview with the PTA at the time of the observation verified PT was responsible for performing wound vacuum dressing changes. She also revealed she was not aware that she needed to document the type or number of dressing pieces removed from the wound or packed into the wound. The interview additionally revealed if the wound vacuum stopped working during the night, or times when PT was not available, nursing staff had an order to remove the wound vacuum and cover the wound with a surgical pad until physical therapy could re-apply the wound vacuum. b. Review of wound documentation from 6/30/14 through 8/2/14 showed no documentation of the type or number of dressing pieces removed from the wound or packed into the wound. c. Interview with RN #1 on 8/7/14 at 9:20 AM revealed if a wound vacuum malfunctions nursing staff could take it off and contact the facility supervisor to notify physical therapy. RN #1 also verbalized she had never had any training related to wound vacuum therapy, except applying extra dressing around the wound, and had never documented the number of dressing pieces that were removed. Interview with RN #2 on 8/7/14 at 9:25 PM revealed she had never had a resident with a wound vacuum and she was unsure what to do if the wound vacuum unit malfunctioned.	F 281	F281 cont. 5. Post fall PT screening education to Therapy and nursing staff to be completed with documented competency. 6. Review and revise fall policy to include parameters for timeframes for PT post fall screening. 7. Revise Therapy post fall screen documentation in the EMR to include reason for screen, assessment detail and recommendations. 8. Review and revise process for completion of PT screens and orders to assure timely completion of orders. Outcome: 100% of nursing and PT staff will complete competencies related to Wound Vacs. 100% of wound vac documentation will include dressing placement and removal. 95% of PT screens will be completed in 72 hours. Therapy Manager or designee will collect data utilizing audit tool monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	~~11/07/14~~

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F 281	Continued From page 4 d. Interview with unit manager #1 on 8/7/14 at 10:40 AM revealed several of the facility's nursing staff had been trained related to trouble shooting when the wound vacuum alarmed or wasn't working properly. However, not all the staff had attended the training, and none of the facility's nursing staff had been educated on changing the wound vacuum dressing. According to Federal Drug Administration (FDA) Medical Device Safety Alert Public Notice dated February 24, 2011 and entitled, "Update on Serious Complications Associated with Negative Wound Therapy Systems", the following reports were received by the FDA, "In the last two years, FDA received six death and 77 injury reports associated with NPWT systems...27 reports indicated infection from retention of dressing pieces in the wound. Retention of foam dressing pieces and foam adhering to tissues or imbedded in the wound were noted in 32 injury reports. The majority of these patients required surgical procedures for the removal of retained pieces, wound debridement, and treatment of wound dehiscence, as well as additional hospitalization and antibiotic therapy." The following recommendations were listed, "Wound infections may develop if pieces of dressing are retained in the wound. To prevent this complication, device instructions recommend counting the total number of dressing pieces used in the wound and documenting that number on the outer adhesive film dressing and in the patient's medical record. Teach the caregiver to count the number of dressing pieces removed to make sure that all pieces are accounted for." In addition, the FDA recommended, "Healthcare providers using NPWT devices should undergo appropriate training on device use, including indications and	F 281		

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F 281	Continued From page 5 contraindications, and recognition and management of potential complications." 2. Review of the medical record showed an order dated 5/6/14 for resident #100 to have a physical therapy (PT) screening after an occurrence of a fall. Review of the medical record failed to show this PT screening was completed. Interview on 8/16/14 at 3:15 PM with RN #1 revealed she was unable to locate PT notes or nursing notes to show the screening was completed. Interview with nurse manager #1 on 8/6/14 at 11:56 AM verified the PT department was contacted and they had not completed the screening ordered on 5/6/14. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, nursing must function under the direction of a licensed physician.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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, medical record review, staff interview, and review of facility policy, the facility failed to ensure 1 of 8 sample residents (#33) who required extensive assistance performing ADLs received assistance with	F 312		

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F 312	Continued From page 6 hygiene. The findings were: Review of the medical record showed resident #33 was admitted to the facility on 10/9/12 with diagnoses including Alzheimer's disease. Review of the quarterly MDS assessment dated 7/21/14 revealed the resident was severely cognitively impaired and required extensive assistance from staff to complete ADLs including bathing and hygiene. Review of the undated care plan identified the resident as being at risk for a self care deficit related to cognitive impairment, decreased mobility, and difficulty with ADLs. Interventions included assistance with shaving, hair and nail care. The following concerns were identified: a. Observation on 8/4/14 at 3:40 PM revealed the resident was seated in the main dining room. The resident had long, jagged fingernails and the nailbeds were encrusted with thick, brown matter. The resident's beard and hair were untrimmed, long, and unkempt. Subsequent observations on 8/6/14 at 8:30 AM and 8/7/14 at 9:35 AM showed the resident continued to have long, jagged fingernails encrusted with thick, brown matter and his/her beard and hair remained untrimmed, long, and unkempt. b. Interview with clinical supervisor #1 on 8/7/14 at 9:35 AM verified staff were supposed to trim and clean residents fingernails as needed. The interview further confirmed the resident liked to have a full beard, however, the residents hair and beard should have been trimmed, and his/her fingernails should have been trimmed and cleaned. c. Review of facility policy and procedure dated 7/27/12, and entitled, "ADL and Personal Care", showed, "All activities related to personal care and hygiene will be completed according to	F 312	F 312 Correction for cited residents: Resident #33 Resident received hair cut and beard trimming on 08/22/14. Nails were trimmed and cleaned on 08/09/14 Identification of other residents will occur by: All residents have the potential to be affected by inability to provide self care and ADL resulting in inadequate personal hygiene. Systemic Corrective Action: 1.Social services will develop list of resident with minimal family support for personal hygiene upkeep and review quarterly during care planning meetings for changes and additions. 2.Develop and implement weekly nursing rounds to include a review of each resident's plan of care. 3.Nursing staff education related to ADL assistance of residents at new orientation and ongoing. 4. Review and revision of ADL policy to reflect MDS and assistance with personal grooming needs. 5. Resident and guest coordinator to develop process to assist with personal grooming appointments for residents needing assistance.	~~08/31/14~~ ~~08/31/14~~ ~~11/07/14~~ 9/26/14

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F 312	Continued From page 7 nursing and CNA standards of care...Nail Care 1. Proper nail care can aid in the prevention of skin problems. 2. Nail care includes daily cleaning and regular trimming...4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin..."	F 312	F312 cont. Outcome 100% residents in LTC facility will have a neat groomed personal appearance. DON or designee will collect data from nurse rounding reports monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	~~11/07/14~~
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Two (2) medication errors were observed out of 31 opportunities for error, which resulted in an error rate of 6.45%. The findings were: Observation on 8/6/14 at 10 AM showed medication aide #1 give resident #72 artificial tears, 1 drop in each eye. In addition, the aide administered Nasonex nasal spray, 1 spray each nostril. Review of the physician orders dated 7/22/14 showed the resident was to receive 2-3 drops in each eye of the medication. Further, the aide was to administer 2 sprays in each nostril once daily. During an interview with the medication aide at 4:35 PM that same day, she confirmed the medications were not administered as ordered.	F 332	F 332 Correction for cited residents: Resident # 72 Individualized staff education regarding medication administration practices completed Identification of other residents will occur by: All residents have the potential to be affected by medication errors and medication practices. Systemic Corrective Action: 1.Medication administration competencies for all nurses and medication aides will be completed . 2.Nurse managers to complete monthly random medication pass audits utilizing consistent audit tool with followup for any variances. Outcome Medication error rate will be maintained at or less than 5%. DON or designee will collect data from medication audit reports monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	~~08/31/14~~ ~~08/31/14~~ ~~11/07/14~~ 9/26/14 ~~11/07/14~~
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 8 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 and staff interview, the facility failed to ensure the kitchen environment was sanitary. The findings were: Observation on 8/4/14 at 3:40 PM and on 8/6/14 at 4:30 PM showed three ceiling vents located above the steam table and food preparation areas were in need of cleaning. These vents and the ceiling tiles around them had a buildup of dark-colored dust and grease. Interview with the dietary manager on 8/6/14 at 4:45 PM verified the ceiling vents and tiles needed to be cleaned. Observation on 8/6/14 at 4:30 PM showed the walk-in refrigerator ceiling had a thick buildup of dust around the area of the condenser fans. At that time, there were uncovered cups of gelatin for the evening meal on trays in the walk-in refrigerator. Interview with the dietary manager on 8/6/14 at 4:45 PM verified the area needed to be cleaned and the food should have been covered. According to Food Code 2013, U.S. Public Health Service; 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of	F 371	F 371 Correction for cited residents: Three ceiling vents cleaned on 08/06/14. Fans and condensers in the freezer cleaned on 08/31/14. Covers purchased and in place by 08/15/14 for food racks in refrigerators. Identification of other residents will occur by: All residents have the potential to be affected by unsanitary food conditions. Systemic Corrective Action: 1.Review and revision of weekly and monthly cleaning schedules to include vent/fans and food storage inspections. 2.Education of all Nutrition staff will be completed related to food storage in the coolers with documented competency. 3. Semi-monthly audits to be completed by manger or designee. Outcome: 100% completion of all cleaning duties scheduled cleaning in the nutrition department. Supervisor or designee will collect data from cleaning schedule audits monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	~~08/31/14~~ ~~08/31/14~~ ~~11/07/14~~ 9/26/14 ~~11/07/14~~

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F 371	Continued From page 9 equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		