STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	C 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or 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).	F 225	This facility will ensure any allegation of abuse is thoroughly investigated and report will be made to State survey agency. 1) Investigation of resident #19 allegation of abuse will be done by Administrator, Director of Nursing Services and Social Service Director. Investigation will include interview of resident, CNA staff, LN staff, and close observation of resident condition and cares. Results of investigation will be reported to State agency. 2) Social Service Director will visit with all residents regarding actions of staff towards them during cares. All resident interviews will be documented by Social Service Director. Any resident identified to have concerns regarding	

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

Janice Cowan — Administrator — 7/18/14

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 w/ Ms Jackie Claudler, NHA on 7/24/14 @ 3:13 pm

POC accepted.
POC = 8/9/14

Janelle Cook, ONRC

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F 225	Continued From page 1 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 medical records, State survey and certification agency records, and staff interview, the facility failed to investigate and report to the State survey and certification agency 1 of 1 allegations of abuse discovered during record review. The findings were: Review of a social service progress note dated 12/31/13 for resident #19 revealed "[the resident] has commented several times this month that one of the night aides has been rough with [him/her]. I have spoken with the aides about this and they will keep an eye out. May be [his/her] paranoia. Will continue to monitor." No evidence of an investigation into this allegation was found. Review of State survey and certification agency records revealed no report was made to that office of an abuse allegation. During an interview on 6/26/14 at 2:05 PM, the social services director confirmed the allegations were not thoroughly investigated, and no report	F 225	staff provided care, will result in investigation of concern and report to State agency. 3) Social Service Director will be in-serviced by Administrator regarding the need to immediately recognize and report any concern or verbalization by any resident regarding abuse. 4) Monitored by Social Service Director through quarterly reporting of resident concerns to Quality Assurance Committee.	8/9/14 ~~09/09/14~~

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F 225	Continued From page 2 was made to the State survey and certification agency.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and resident interview, the facility failed to ensure staff treated 1 of 9 sample residents (#2) and 1 non-sample resident (#6) with dignity and respect. The findings were: 1. Review of the 5/5/14 significant change MDS assessment showed resident #2 required extensive assistance with dressing and bathing, and was totally dependent for transfers and toilet use. The following concerns were identified: a. Interview on 6/25/14 at 6:25 PM with resident #2 revealed s/he was uncomfortable and had requested to be laid down. The resident stated s/he was having pain and discomfort and s/he had to "sit here and cringe" because s/he "can't get away from it [the pain]." The resident was unable to transfer without assistance. At that time, CNA #1 who had been asked by the resident for assistance, came back and told the resident it would be 30 minutes before s/he could be helped. At 6:30 PM the resident again asked the CNA how much longer it would be, telling the aide s/he was experiencing pain and discomfort. b. At 6:53 PM, the resident wheeled	F 241	This facility will ensure and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1) A. Resident #2 will be observed closely throughout the day by Director of Nursing Services. DON will visit with resident #2 frequently throughout the day to identify needs and concerns of resident #2. DON will observe interaction between resident #2 and staff. DON will intervene for resident #2 at anytime staff is noted to not address the requests or concerns of resident #2. DON will address CNA #1 regarding the need to listen and provide care to resident #2 upon any request, concern or complaint by resident #2. DON will address CNA's #2 & #3 regarding listening to the concerns of resident #2 and providing care as requested and safe. They will also be visited with regarding the need to report all resident #1's concerns and complaints of pain to the LN staff immediately. Resident #1's care plan will be reviewed and updated as appropriate to include resident requests and comforts. B. Resident #6 will have full pain	

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F 241	Continued From page 3	F 241		

him/herself into his/her room, and put on the call light. CNA #2 and CNA #3 responded to the call light and began to prepare the resident for bed. A hospital gown was presented to the resident, and s/he said, "Do I have to wear one of those? I don't like it." CNA #3 responded, "Yes. You sweat a lot." The resident again stated that s/he did not like to wear the hospital gowns, but allowed the CNAs to dress him/her in it. At 6:59 PM, the resident was transferred to bed, at which time s/he complained of pain, stating the pain made him/her "want to cry; hurts like the devil." CNA #3 responded to this complaint of pain saying, "That comes from being a diabetic." At 7:54 PM, RN #1 received report that the resident was complaining of itching and pain. The RN assessed the resident for itching, and wondered aloud if the resident was suffering from itching due to the hospital gown that s/he was wearing, and commented the resident usually wore a t-shirt to sleep in. The RN assisted the resident in removing the hospital gown, and donning a t-shirt, at which time the resident stated s/he was "glad to get that damn thing off." The RN also administered pain medication at that time.

2. Observation on 6/25/14 at 6:28 PM revealed several residents were seated at a table in the living area. Resident #6 was seated in a wheelchair at the table and made several comments about pain s/he was experiencing in his/her legs. RN #1 was in the area preparing to pass evening medications. On 6/25/14 at 6:32 PM, the resident complained to the DON stating, "My leg hurts tonight. My leg always hurts." The DON responded, "Maybe [RN #1] has something he can give you." The DON did not communicate the resident's complaint of pain directly to the RN. Interview with the resident at 6:40 PM revealed

assessment review done by DON. Pain assessment will include leg pain and positioning. DON will visit with RN #1 regarding need to immediately intervene for resident #6 at any complaint of pain. Interventions might include, pain medication, position change, transfer to more comfortable chair, at a minimimum. Administrator will inservice DON regarding need to immediately notify appropriate staff when DON is notified of resident concern. Interdisciplinary Team will review and update care plan as appropriate based on resident #6 pain assessment.

2) Director of Nursing Service will observe all staff to resident interaction watching for resident requests and concerns and resultant interventions. Any concerns or requests identified to be ignored or set aside by staff will result in immediate intervention by DON to ensure resident concerns are being addressed by all staff. Director of Nursing Service will do review of pain assessment for all residents. Interdisciplinary Team will review and update all resident pain Care Plans as appropriate. DON will notify all staff of changes to pain care plans and appropriate and immediate interventions.

3) DON will inservice all staff regarding need to listen to resident concerns

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F 241	Continued From page 4 being moved from the wheelchair to a recliner "would help" relieve the discomfort. This comment was in the presence of RN #1 who made no attempt to reposition the resident, or seek out an aide who could transfer the resident. At 8:45 PM the resident continued to be seated in the same location at the table in his/her wheelchair. Review of the medical record on 6/26/14 showed no documentation related to the resident's complaints of pain.	F 241	and requests and provide cares consistent with resident wishes. DON & Administrator will empower staff to report any resident requests which might not be consistent with care plans so that care plans and resident concerns can work together to ensure best resident care. DON will inservice all staff regarding need to immediately intervene for any complaints of	8/9/14 9/9/14
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident interview, the facility failed to assess pain for 1 random non-sample resident (#6) who voiced complaints of pain. The findings were: Observation on 6/25/14 at 6:28 PM revealed several residents seated at a table in the living area. Resident #6 was seated in a wheelchair at the table and made several comments about pain s/he was experiencing in his/her legs. RN #1 was in the area preparing to pass evening medications. On 6/25/14 at 6:32 PM, the resident complained to the DON stating, "My leg hurts tonight. My leg always hurts." The DON	F 309	This facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. 1) Resident #1 will have pain assessment done by Director of Nursing Services. Pain assessment will result in Interdisciplinary Team Care Plan review and update to include pain interventions. DON will inservice RN #1 regarding need to listen to resident and recognize need for intervention upon any complaint of pain. 2) DON will do pain assessment on all residents which will result in Interdisciplinary Team review and appropriate update of all resident pain Care Plans. 3) DON will inservice all staff regarding need to assess and document all complaints of pain by all residents. Staff will review Care Plans to ensure all pain interventions are being	

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F241 Continued

pain including notifying LN, position change, transfer to another chair and recognition that no resident should be allowed to stay in pain for any amount of time.

4) Monitored by DON through quarterly reporting of resident/staff observation and resultant appropriate intervention of care. to the QA Committee.

9/9/14

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F 309	Continued From page 5 responded, "Maybe [RN #1] has something he can give you." The DON did not communicate the resident's complaint of pain directly to the RN. Interview with the resident at 6:40 PM revealed being moved from the wheelchair to a recliner "would help" relieve the discomfort. This comment was in the presence of RN #1 who made no attempt to reposition the resident, or seek out an aide who could transfer the resident. At 8:45 PM the resident continued to be seated in the same location at the table in his/her wheelchair. Review of the medical record on 6/26/14 showed no documentation related to the resident's complaints of pain.	F 309	Implemented. LN's will be inserviced by DON regarding appropriate documentation of pain to include onset, site, level, intervention, post intervention pain levels. 4) Monitored by DON through quarterly reporting of appropriate pain intervention and documentation by staff to Quality Assurance Committee.	8/9/14 9/9/14
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure residents having pressure sores received physician-ordered treatment and services to promote healing for 1 of 1 sample resident (#2) and 1 non-sample (#25) resident with pressure sores. The findings were:	F 314	This facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores. 1) A. DON will contact MD for pressure sore intervention orders for resident #2. LPN #1 & #2 will be inserviced regarding need to provide all pressure ulcer treatment under order of MD. B. DON will contact MD for pressure ulcer intervention order for resident #25. LPN #1 & #2 will be inserviced regarding need to provide all pressure ulcer treatment under order of MD. 2) DON will review the medical record of all resident's identified with pressure sores. Any resident noted to have pressure sore interventions without MD orders will immediately	

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F 314	Continued From page 6 1. Review of the 3/5/14 significant change MDS assessment revealed resident #2 had diagnoses that included peripheral neuropathy and diabetes mellitus, was at risk for pressure ulcers, required extensive assistance with bed mobility and dressing, and required total assistance with transfers and toilet use. Review of a late-entry clinical note for 6/21/14 at 4:30 PM showed the resident had an Allevyn dressing covering a sore measuring 0.8 centimeters (cm) to the "left gluteal fold," and scant light yellow drainage was noted. Observation of wound care with LPN #1 on 6/26/14 at 11:11 AM revealed the resident had an Allevyn dressing on his/her left buttock. The dressing was removed, the wound was cleansed with sterile normal saline, and a fresh Allevyn dressing was applied. The following concerns were identified: a. Interview with LPN #2 on 6/26/14 at 3:30 PM revealed the nursing staff treated pressure ulcers according to standing orders. Review of the facility standing orders entitled "Medical Protocol Orders" showed the treatment for pressure ulcer or wound care to be: "Follow specific M.D. order for surgical wounds or pressure ulcers." a. Interview with the DON on 6/26/14 at 2:05 PM revealed the facility had no physician orders for the treatment of this wound. 2. Review of the 5/12/14 quarterly MDS assessment revealed resident #25 was at risk for pressure ulcers. Review of a Weekly Skin Assessment dated 6/18/14 revealed, "Resident with 0.25 cm open area to right inner buttock between coccyx area and buttock fold. Alleyvn applied to affected area." Observation of wound care with LPN #2 on 6/25/14 at 3:30 PM revealed the resident had an Alleyvn dressing applied to	F 314	Sore orders. 3) DON will inservice all LN staff regarding need to provide pressure ulcer interventions only under the direction and order of MD. 4) Monitored by DON/designee through quarterly reporting to Quality Assurance Committee of Medical Record review of pressure sore orders by MD.	8/9/14 ~~9/9/14~~

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F 314	Continued From page 7 the right lower gluteal furrow. The dressing was removed, revealing an area of discolored skin that appeared closed. A fresh Allevyn dressing was applied. The following concerns were identified: a. Interview with LPN #2 on 6/26/14 at 3:30 PM revealed the nursing staff treated pressure ulcers according to standing orders. Review of the facility standing orders entitled "Medical Protocol Orders" showed the treatment for pressure ulcer or wound care to be: "Follow specific M.D. order for surgical wounds or pressure ulcers." b. LPN #2 was unable to locate physician orders for treatment of this wound. c. Interview with the DON on 6/26/14 at 2:05 PM confirmed the facility had no physician orders for the treatment of this wound.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 safety equipment was used during 1 of 3 observations of resident transfers. The findings were:	F 323	This facility will ensure that the resident environment remains free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. 1) DON will observe resident #5 transfers by staff and will intervene immediately upon identification of any transfer noted to be anything but lift transfer. CNA's #1 and #4 will be inserviced regarding safe transfers of resident #5 and need to read and follow care plans. 2) DON will observe all staff during all resident transfers. DON will immediately intervene upon any identification of unsafe transfer practices	

F323 Continued

4) Monitored by DON through quarterly reporting of observation of safe transfer practices for all residents by all staff.

to the QA Committee.

8/9/14

9/9/14

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F 323	Continued From page 8 Review of the 5/2/14 quarterly MDS assessment showed resident #5 required extensive assistance from staff for transfers. Review of the care plan last reviewed on 8/4/13 showed the resident required a mechanical "sara-lift" or "lift for 2 person transfer." Observation on 6/24/14 at 9:55 AM showed the resident was transferred from the wheelchair to a recliner by CNA #1 and CNA #4. The CNAs used an under the arms grab and lift. Interview with the DON on 6/26/14 at 3:25 PM verified the transfer was unsafe.	F 323	by staff. 3) All staff will be inserviced by DON regarding need to use safe transfer practices for all residents. All staff will be instructed to follow Care Plans to ensure they understand which method of transfer has been determined safe and appropriate for all residents.	8/9/14 ~~9/9/14~~
F 327 SS=D	483.25(l) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff and resident interview, the facility failed to ensure hydration status was maintained for 2 of 9 sample residents (#3, #5). The findings were: 1. Review of the 5/2/14 quarterly MDS assessment showed resident #5 had a diagnoses of dementia and required extensive assistance with eating. Review of the 7/10/13 registered dietitian (RD) assessment showed the resident's estimated fluid needs were 1775 mls (milliliters) per day. The following concerns were identified: a. Observation on 6/23/14 at 4:40 PM showed the resident was seated in a recliner in the living area. When talking to the resident it was noted his/her lips were dry and cracked. b. Observation on 6/24/14 at 9:55 AM showed	F 327	This facility will provide each resident with sufficient fluid intake to maintain proper hydration and health. 1) A. DON/designee will observe resident #5 throughout the day and observe for staff offering and providing fluids at each contact and multiple times throughout the day. DON/designee will intervene any time staff is identified to not be offering/providing fluids to resident #5. Inputs will be recorded by CNA staff. B. DON/designee will observe resident ~~#3~~ #5 throughout the day and observe for staff offering and providing fluids at each contact and multiple times throughout the day. DON/designee will intervene anytime staff is identified to not be offering/providing fluids to resident #5. Inputs will be recorded by CNA staff. 2) DON/designee will observe all res	

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F 327	Continued From page 9 the resident's lips remained dry and cracked. c. Review of the fluid intake records showed the amounts of fluids recorded were with meals. From 6/20/14 to 6/24/14 the records showed the resident averaged 984 mls of fluids per day for those five days. d. Observation on 6/25/14 at 8:17 PM showed the resident was in bed and there was a water pitcher on the bed side table. However, a fall mat was on the floor next to the bed, placing the table and water out of the resident's reach. 2. Review of the 6/13/14 quarterly MDS assessment showed resident #3 was independent for eating. However, the resident had experienced significant weight loss and review of the 2/6/14 care plan for dehydration/fluid maintenance showed fluids were to be encouraged, and a "hydration protocol" followed. The following concerns were identified: a. Observation on 6/25/14 at 8:05 PM showed CNA #2 helped the resident with evening care and transferred the resident to bed. The CNA failed to encourage or offer the resident fluids prior to leaving the room. b. Review of the RD initial assessment showed fluid needs were estimated to be 1650 mls per day. Review of the fluid intake records which recorded intake at meals showed the average fluid intake per day for this resident from 6/20/14 to 6/24/14 was 784 mls/day. 3. Interview with CNA #6 on 6/26/14 at 10:10 AM revealed the education CNAs received was to offer and encourage fluids with each resident contact. This CNA further stated resident #5 could drink if a glass was placed in his/her hands, but could not get his/her own fluids. The CNA stated resident #3 could ask for fluids and could	F 327	idents at each contact and multiple times throughout the day. DON/ designee will observe CNA's passing, offering and assisting residents with hydration/nutrition pass at least 3x/day. If staff is identified to not provide hydration/nutrition pass 3 times per day, DON will immediately intervene to ensure hydration/nutrition passes are being done for residents. Night time water pitcher fill will be checked by DON/ designee to ensure all water pitchers are being filled for each resident in the evenings. DON/designee will observe medical record for documentation of fluid input. 3) DON will inservice all staff regarding need to provide hydration for all residents which will include hydration/nutrition pass 3x daily plus filled water pitchers both morning and night. Staff will be instructed to encourage and assist all residents with assist needs. All inputs will be documented in the resident's medical record. DON and Administrator will update hydration policy and staff will be inserviced regarding facility policy concerning appropriate resident hydration. 4) Monitored by DON/designee through quarterly reporting to Quality Assurance Committee of obser-	

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	536019	A. BUILDING _____ B. WING _____	C 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	360 SOUTH US HWY 20 BASIN, WY 82410

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F 327	Continued From page 10 drink if provided fluids; however, s/he was confused and needed encouragement. 4. In a group interview of 14 residents on 6/25/14 at 10 AM, the residents raised concerns that staff did not consistently ensure water pitchers were replenished at night. 5. Interview with the DON on 6/26/14 at 3:25 PM verified she was unable to find a "hydration protocol." However, she expected staff to pass water to each resident room daily, to offer fluids at meals, activities, and when resident cares were provided.	F 327	vations and documentation of all residents requiring careful hydration interventions.	8/9/14 ~~7/9/14~~
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 observation, medical record review, and staff interview, the facility failed to maintain a medication error rate under five percent (%). Two errors occurred out of 26 opportunities for error, resulting in an error rate of 7.69%. Residents affected by these errors were non-sample residents #12 and #7. The findings were: 1. Observation of the medication pass on 6/26/14 at 11:30 AM revealed resident #12 was administered sucralfate (Carafate) 1 gram (G). The resident then went to the noon meal where s/he was observed to be eating 30 minutes later at 12 PM. Review of the medical record revealed	F 332	This facility will ensure that it is free of medication error rates of five percent or greater. 1) A. DON will contact MD regarding resident #12 Carafate. Order will be obtained or medication will be discontinued. LPN #2 will be inserviced by DON regarding appropriate timing of Carafate. Time of medication administration for Carafate will be reviewed and adjusted as appropriate. B. Resident #7 will be given Warfarin at the time ordered. 2) DON will watch all LN's during med passes and will immediately intervene if any medication is given at an inappropriate time.	

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F 332	Continued From page 11 no order for this medication. Interview with LPN #2 revealed she was unable to find a signed order in the chart. Interview with the DON at 12:30 PM revealed the Electronic Medical Record (EMR) had a box that was checked as signed by the doctor, but she was unable to produce a signed, dated and timed verbal or written order for this medication, and she confirmed there was no telephone order (TO) in the medical record. According to Lexi-Comps Drug Information Handbook for Nursing 2010, 11th edition, pg. 1245, sucralfate should be administered with water on an empty stomach one hour before or two hours after meals. According to Perry, Potter & Elkin Nursing Interventions and Clinical Skills 2012, 5th edition, a physician's order is required for all medications administered by a nurse, in written or electronic form that includes the date, time and signature of the prescriber. 2. Observation of the medication pass on 6/26/14 at 11:40 AM revealed resident #7 was administered warfarin sodium (Coumadin) 1 milligram (mg). Review of the medical record revealed the order for this medication was to be administered at 8:00 AM every day. The medication was given three hours and 45 minutes late. According to Lexi-Comps Drug Information Handbook for Nursing 2010, 11th edition, pg. 1396, this is a high alert medication with an increased risk of causing significant harm when used in error, and states to administer at the same time each day which enables titrating the resident's blood level to a specific therapeutic range.	F 332	3) DON will inservice all LN staff regarding need to provide all medications timely and review Drug Handbook with LN staff to ensure LN's understand where to find information regarding implications of inappropriate administration of medications. LN's will be inserviced regarding the 5 R's of medication pass including right order. Any medication noted to not have an order will be immediately reviewed with MD to obtain order or discontinue medication. 4) Monitored by DON through quarterly reporting to Quality Assurance Committee of appropriate timing of medications at medication pass and review of all medications and associated MD orders.	8/9/14

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 sanitary conditions in 2 of 2 kitchens. The findings were: 1. Observation on 6/23/14 at 4:10 PM in the main kitchen showed there were dried food crumbs and debris underneath the electric slicer located on a preparation table. The slicer was not in use and had been cleaned; however, the area around the adjustment dial was soiled with a build up of food, grease, and grime. Observation on 6/25/14 at 4:30 PM showed the slicer and the counter underneath the slicer remained in the same condition. 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 equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation on 6/23/14 at 4:10 PM showed the walls and ceiling in the produce walk-in refrigerator were in need of cleaning. There was a	F 371	This facility will ensure food is stored, prepared, distributed and served under sanitary conditions. 1) A. Dietary Manager will immediately clean slicer, including dial, preparation counter, and counter under slicer. B. Dietary Manager will immediately clean produce walk-in cooler ceiling and walls. C. Dietary Manager will immediately clean back wall of cooler. D. Dietary Manager will immediately dispose of all disposable containers in dietary department. E. Activities Director will immediately clean or make provision for the immediate cleaning of the kitchenette ice machine. F. Dietary Manager will dispose of all disposable containers and will ensure slicer is cleaned immediately.	

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F 371	Continued From page 13 black and brown dusty substance around the light fixture and on the ceiling near the light and the condenser fan. In addition, the wall near the light switch and the thermometer was dirty with a dark-colored dust and grime. 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 equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Observation of the defrost cooler on 6/26/14 at 11:05 AM showed there were areas on the back wall of the cooler with dark-colored clustered spots. Interview with the dietary manager at the time of observation verified the areas needed to be cleaned. 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 equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. During observations of the main kitchen on 6/23/14 at 4:10 PM and 6/26/14 at 11 AM, it was noted that disposable containers were being used to store leftover food in. These containers were observed in use in the coolers with food not original to the containers label. In addition, there were multiple cottage cheese, and margarine containers cleaned and stored for later use. According to Food Code 2013, U.S. Public Health Service definitions: (2) "Single-use articles" includes items such as wax paper, butcher paper, plastic wrap, formed aluminum FOOD containers, jars, plastic tubs or buckets, bread wrappers, pickle barrels, ketchup bottles, and number 10	F 371	2) Dietary Manager will observe all dietary department areas for cleanliness. Any area identified with any grime or discoloration, will be immediately cleaned by Dietary Manager. Activity Director will observe all Kitchenette areas for cleanliness. Any area identified to be in need of cleaning, will be immediately cleaned by Activity Director/ designee. 3) Dietary Manager will develop cleaning schedule which will include slicer, slicer dial, preparation counter, counter under slicer, produce walk-in cooler ceiling & walls, cooler and disposable containers and all other areas of the department. Dietary Manager will assign cleaning tasks to dietary staff and Manager will observe department for clean surfaces daily. Dietary Manager will inservice dietary staff regarding need to clean all dietary surfaces and follow cleaning schedule as developed. Activity Director will develop cleaning schedule for Kitchenette and will assign cleaning duties as appropriate. Activity Director will inservice staff regarding need to observe cleanliness of Kitchenette and follow cleaning schedule for Kitchenette.	

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F 371	Continued From page 14 cans which do not meet the materials, durability, strength, and cleanability specifications under §§ 4-101.11, 4-201.11, and 4-202.11 for multiuse UTENSILS. 5. Observation of the activities kitchen on 6/26/14 at 11:10 AM showed the ice/water dispenser was not clean. The spout where the ice and water came out was crusted with hard water deposits. Additionally, the drip/drain tray was discolored with rust-colored liquid and hard water build up. Interview with the dietary manager at that time verified it was the responsibility of the activities staff to maintain the cleanliness of the machine. 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 equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 6. Interview with the dietary manager on 6/26/14 at 11:05 AM verified the containers were not intended for re-use. The manager also verified the slicer needed to be cleaned more thoroughly.	F 371	4) Monitored by Dietary Manager and Activity Director through quarterly reporting to Quality Assurance Committee regarding observation of cleanliness of dietary department and kitchenette and monitoring of cleaning schedule.	8/9/14 ~~9/9/14~~
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431	This facility will ensure drugs and biological used in the facility are labeled in accordance with accepted principles, and include appropriate accessory and cautionary instructions. 1) A. DON will observe medication pass of LPN #2 and instruct that pre-pour is not acceptable practice within the facility. LPN #2 will be instructed to provide medications to resident as they are removed from pharmacy packaging and	

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F 431	Continued From page 15 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. 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, staff interview, and consultant pharmacist review, the facility failed to ensure the proper storage and labeling of medications. This practice affected all residents in the facility. The census at the time of survey was 25. The findings were: 1. Observation of the medication room on 6/23/14 at 4:38 PM showed 3 paper souffle cups on top of the medication cart. The souffle cups were labeled with resident initials and the date, but were not labeled with the contents of the cup. Interview with LPN #2 at the time of observation	F 431	document when medications have been consumed by resident. B. DON will observe resident medication pass to ensure LPN #2 does not pre-pour and crush medications prior to providing medications to any resident. C. DON will inform LPN #1 that medication pre-pouring is not an acceptable practice in this facility. D. DON will inform RN #1 that medication pre-pouring is not an acceptable practice in this facility. E. DON will work with facility Pharmacist to provide education to LN staff regarding unsafe practice of pre-pouring medications including medication names, times, and instructions. F. Administrator and DON will provide education to LN staff regarding the unsafe practice of pre-pouring medications and the concern for increased medication errors based on this practice. 2) DON will work with all LN's to help establish new workflow which will include passing medications to residents without pre-pouring medications.	

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F 431	Continued From page 16 revealed the medications on top of the medication cart were "set up for supper time." 2. Observation of the medication room on 6/25/14 at 11:08 AM showed 11 souffle cups with medications in them sitting on the medication cart. The cups were labeled with resident's name, the date, and the time the medications were supposed to be administered. They were not labeled with the contents of the cup. One of the souffle cups contained crushed medication. Interview with LPN #2 at that time revealed this crushed medication was a controlled substance. However, the cup was not labeled with its contents, and due to being crushed, the medication could not be identified by its shape, color or other identifying marks. The LPN stated that pre-preparing (pre-pouring) medications was her standard practice, and that not only had all of the 12 PM medications been pre-poured, but all of the 6 PM medications for 6/25/14 had been pre-poured as well. 3. Interview with LPN #1 on 6/26/14 at 8:32 AM revealed that her normal practice was to pre-pour medications. 4. Interview with RN #1 on 6/26/14 at 7:20 PM revealed pre-pouring medications in the facility was a common practice, and he pre-poured medications on those shifts when he had time to do so. 5. Interview with the consulting pharmacist on 6/26/14 at 8:06 AM revealed 2 months previously the facility, in an attempt to eliminate the practice of pre-pouring, worked with the pharmacy to streamline the medication administration process. The pharmacy began grouping each resident's	F 431	3) Administrator and DON will inservice all LN staff regarding medication passes and the expectation of not pre-pouring any medications. Attention will be made to the safe practice of medication pass and work flow of medication pass. 4) Monitored by DON through quarterly reporting to Quality Assurance Committee regarding medication pass observations and lack of LN's pre-pouring medications.	8/9/14 ~~8/9/14~~

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F 431	Continued From page 17 medications together based on the administration time such as AM and PM. The scheduled medications could then be administered by punching out a single foil package for each resident at that time. Further, the consulting pharmacist expressed concern about the safety of pre-pouring medications, because once medications were dispensed from pharmacy containers, the medications were unlabeled and vulnerable to tampering or contamination. 6. Interview with the administrator and DON on 6/26/14 at 2:05 PM revealed the facility practice of pre-pouring medications had been "done forever." They were aware that pre-pouring medications may contribute to errors, and had been attempting to eliminate the practice of pre-pouring medications, with limited success.	F 431		
F 502 SS=D	483.75(j)(1) ADMINISTRATION 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 medical record review, and staff interview, the facility failed to ensure laboratory testing was completed as ordered by the physician for 1 of 9 sample residents (#3). The findings were: Review of the medical record showed resident #3 was being treated for hypothyroidism with the medication Levothyroxine daily. Review of a physician order noted by the nurse on 6/6/14	F 502	This facility will ensure laboratory testing is completed as ordered by the physician. 1) DON will have TSH laboratory testing performed immediately on resident #3. 2) DON/designee will review all resident records to ensure all ordered laboratory tests have been completed. 3) DON will work with laboratory director to develop a process to ensure all resident laboratory tests are performed. Process shall include laboratory notification of new facility resident.	

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F 602	Continued From page 18 showed, "TSH on 6/9/14." TSH is a laboratory test for thyroid stimulating hormone. Further review of the medical record failed to show results of the TSH testing. Interview with the DON on 6/26/14 at 3:25 PM verified the laboratory test was missed and had not been done.	F 602	4) Monitored by DON through quarterly reporting to Quality Assurance Committee of laboratory order and associated results and MD orders.	8/9/14 ~~8/9/14~~
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the records were accurate and complete for 3 of 9 sample residents (#1, #8, #13). The findings were: During the survey, medical record information for residents was available in two formats. Some items were accessible in a paper/hard copied format and other information including the MARs were available in an electronic format. Attempts to retrieve information from the electronic MAR was time consuming and some of the information	F 514	This facility will ensure clinical records are complete, accurately documented, readily accessible and systematically organized. 1) A. Skipped and missed Fentanyl & Tramadol medication doses for resident #1 will be investigated by DON and note placed in electronic record Nursing Notes providing full explanation of these medication concerns. B. Missed naproxene and cranberry medication doses for resident #13 will be investigated by DON and note placed in electronic record Nursing Notes providing full explanation of these medication concerns. C. Missed morphine, levodopa and oxycodone medication doses for resident #8 will be investigated by DON and note placed in electronic record Nursing Notes providing full explanation of these medication concerns.	

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F 514	Continued From page 19 was not able to be printed out. Review on the computer showed the information related to "skipped" and "missed" medication entries was not complete. The following concerns were identified: a. Review of the June 2014 electronic MAR showed missed and skipped medication doses for resident #1. These medications were Fentanyl and Tramadol which are controlled narcotic pain medications. Review of the paper controlled narcotic record showed the 1 missed dose of Fentanyl (a pain medication in a patch form changed every three days) was recorded as having been administered to the resident on 5/31/14 and removed and destroyed on 6/3/14. This was not consistent with the electronic MAR which showed there was a missed dose on 6/1/14. Review of the paper controlled narcotic record for the Tramadol 50 milligrams (mg) showed the 4 doses were given; however this did not explain why they were shown as "skipped" doses on the electronic MAR. b. Review of the electronic MAR for resident #13 showed 7 days (6/3, 6/7, 6/8, 6/16, 6/17, 6/24, 6/25) when there were 2 missed doses of medications on each of those days. There was no information as to why the doses of naproxene and cranberry were missed. c. Review of the June 2014 electronic MAR for resident #8 showed the resident missed a dose of morphine 30 mg on 6/3. No note was made in the electronic record as to why this dose was missed. The resident missed doses of carbidopa-levadopa 25/100 mg on 6/13 and 6/24 without explanation. Additionally, the resident missed doses of oxycodone-acetaminophen 10/235 mg on 6/3, 6/4, 6/8, 6/12, 6/19, 6/20, 6/22, and 6/24 without explanation. d. Interview with the DON on 6/26/14 at 2:25	F 514	D. DON will observe all LN's for missed medications and observe LN documentation of the missed dose. DON will immediately intervene to instruct LN regarding appropriate missed or skipped medication documentation. 2) DON will review all resident medical records for missed/skipped medications and appropriate LN documentation regarding missed/skipped medications. 3) DON and Administrator will inservice LN staff regarding appropriate documentation of missed/skipped medication doses. DON and Administrator will continue inservice regarding electronic record management processes including documentation and retrieval. 4) Monitored by DON through quarterly Quality Assurance Committee reporting of medical record medication documentation review.	8/9/14 ~~9/9/14~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	C 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	368 SOUTH US HWY 20 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 514	Continued From page 20 PM verified she was unable to provide any notes or details as to why these medication doses were not administered to the residents. She further explained the system was set up to include notes and she expected the nurses to document notes when a medication was not administered as ordered.	F 514		