4/22/15

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

PRINTED: 04/08/2015
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
	535019	A. BUILDING _____ B. WING _____	C 03/26/2015

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 A complaint survey was conducted in conjunction with the recertification survey by the Office of Healthcare Licensing and Surveys on 3/23/15 through 3/26/15. The survey was prompted by complaint intake WY00001975. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living 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 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	F 225	F225 Bonnie Bluejacket Nursing Home will 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). 1) All documentation regarding alleged misappropriation of property for resident #25 will be reviewed by Social Service directed and used as example of allegations which should have necessitated call to state survey agency along with investigation of allegation.	

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

Adm — 4/22/15

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
APR 20 2015
Health Care Licensing and Surveys

Accepted w/ change to pg 11.
per Jackie Claussen, NHA
on 4/22/15 @ 11:25 AM

RR 4/22/15

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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, staff interview, and review of policy and procedures, the facility failed to ensure 1 of 1 allegation of misappropriation of property was reported to the state survey agency. The findings were: Review of the social worker's investigation notes to DFS/APS (Department of Family Services/Adult Protective Services), emailed on 1/19/15, showed there was possible financial exploitation of resident #25 by a family member. Further review of the investigation notes showed "I also made [the resident] aware that [the resident] would now be ineligible for Medicaid and would have to move out of the nursing home because of lack of financial resource..." Review of	F 225	2) Social Service Director will review all resident charts for any allegation of abuse. If any allegation of abuse is identified, Social Service Director will immediately notify state survey agency and begin thorough investigation of allegation. 3) Social Service Director will create and implement Abuse Investigation Log to allow monitoring of any and all allegations. Log will include proper procedure guidelines which direct staff that notification of state survey agency must be done with any abuse allegation. Social Service Director, Director of Nursing Services, and Administrator will review and be familiar with Abuse Log and Procedure Guidance form and will all have copies available in office. 4) Monitored through quarterly Social Service Director Quality Assurance reporting of abuse log allegations and documentation of appropriate interventions, notifications, investigations and final implementations/determinations.	5/8/15

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F 225	Continued From page 2 the state survey agency's (SSA) records showed no evidence this allegation of misappropriation was reported as required. Interview with the social worker on 3/26/15 at 8:50 AM revealed she was unaware of the reporting requirements. Interview with the administrator on 3/26/15 at 9:15 AM revealed she was aware of the reporting requirements but had not considered this to be an allegation of misappropriation of property. She verified the facility had not reported the incident to the SSA. The resident was discharged on 2/17/15. Review of the facility policy and procedure related to abuse and neglect prohibition revised 6/30/14 showed "All suspected, reported, or actual acts of abuse or investigations of injury of unknown cause will be reported to the Office of health Quality [SSA] ..." The policy included a definition of misappropriation of property but did not include that an allegation of misappropriation of property was reportable to the SSA.	F 226		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 staff interview and policy and procedure review, the facility failed to ensure the abuse policy and procedure was clear and comprehensive. The findings were:	F 226	F226 This facility will ensure policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1) Administrator and Social Service Director will review and update abuse policy to include: A: Consistent abuse definitions throughout the policy. B: Identifying State Survey Agency correctly.	

QR 4/22/15

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F 226	Continued From page 3 Review of the facility's policy and procedure entitled "Patient Abuse/Unknown Cause Injury Investigating/Report" revised on 6/30/14 revealed the following concerns: a. The "Purpose" of the policy included it was "To establish guidelines concerning the reporting and investigation of possible suspected or alleged mistreatment, abuse, or neglect of patient...For use in this policy the term abuse will refer to physical, mental, psychological abuse, neglect, misappropriation of property." Further review of the policy showed a different definition of abuse which was "Abuse includes such actions as using derogatory language to a patient, rough handling, ignoring resident while giving care, directing patient who need toileting assistance to urinate or defecate in their bed, ignoring any request or need by a resident." The definitions of abuse were inconsistent in the same policy. b. Review of the reporting section of the policy and procedure showed "If an incident necessitates being reported to the Office of Health Quality..." The policy and procedure was not updated to reflect the current name of the SSA (state survey agency) and did not include a telephone number for the agency. Further the use of the title "Office of Health Quality" was used an additional 2 times in the document. c. Review of the policy and procedure showed staff would be trained upon hire and annually on abuse identification. However there was no procedure that included how to identify events, such as bruising, irrational fear of certain people, occurrences, and patterns or trends, that might constitute abuse. d. During an interview with the administrator on 3/26/15 at 9:15 AM, she said the policy and procedure would be reviewed and changes made	F 226	C: Addition of procedure to assist staff in how to identify events such as bruising, irrational fear of certain people, occurrences or patterns and trends that might constitute abuse. 2) Interdisciplinary Team, to include, at a minimum, Administrator, Director of Nursing Services, Risk Manager, Social Services Director, will review policy carefully to ensure full understanding of abuse policy and training techniques for inservicing staff regarding how to identify abuse events. 3) All staff, all departments will be inserviced regarding updated abuse policy and requirements for new hires and annual abuse training to include how to identify abuse events. 4) Monitored by Social Service Director through quarterly Quality Assurance reporting of random staff questioning regarding abuse identification and action interventions and reporting.	5/8/15

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F 226	Continued From page 4 as necessary.	F 226		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to ensure preferences and choices were honored for 2 of 9 sample residents (#5, #8) and 1 non-sample resident (#11). The findings were: 1. Review of the 1/27/15 significant change MDS assessment showed resident #5 had diagnoses which included Parkinson's Disease and required extensive assistance with transfers, ambulation, dressing and hygiene. The MDS assessment also showed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14/15. Interview with the resident on 3/24/15 at 9:40 AM revealed s/he had requested to get up early to have coffee prior to breakfast. This was a routine s/he had enjoyed prior to admission. The resident stated although staff were aware of the preference, there was difficulty in getting the assistance in the AM to allow this choice. The resident stated in the past week s/he had gotten to the dining room early one morning. Review of social service progress notes dated 3/16/15 timed	F 242	F242 This facility will ensure resident has the right to choose activities, schedules and health care consistent with his or her interests, assessments, and plans of care. 1) A: Resident #5's preference to get to the dining room early in order to have coffee prior to breakfast will be made available. Care Plan will be updated to address preference. B: Resident #11's choice to go to bed will result in resident being allow to make the choice and be helped to bed. Care Plan will be updated to address resident choice and appropriate staff intervention. C: Resident #8's choice to get ready for bed will result in resident being allowed to make the choice to get ready for bed. Care Plan will be updated to address resident choice and appropriate staff interventions. 2) Interdisciplinary Team will interview all residents and resident families to determine if resident preference and choice is being identified and provided. Any resident noted to have a preference or choice not being provided will have plan to meet that preference/choice put in motion. All resident preference or choice will be placed in care plan and appropriate interventions identified.	

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F 242	Continued From page 5 at 10:15 AM and 3/19/15 timed at 11:15 AM showed the plan was to have the "night aide" get the resident up at 5:30 AM. The notes showed this arrangement created some frustration with the roommate; however, the resident wished to get up early and go to the dining room 15 minutes prior to breakfast. Review of the resident's care plan failed to show the preference or a plan to attempt to accommodate the resident's choice. Interview with the DON on 3/26/15 at 8:25 AM verified she was unaware the resident was not getting to the dining room early in the morning as requested. 2. Observation on 3/25/15 at 6:23 PM showed resident #11 asked CNA #2 to help him/her lay down. At that time the CNA told the resident "you can't go to bed yet, you just ate." The resident again requested to lay down and was told no. The CNA instead took the resident to a table in the common area where 11 minutes later s/he was provided a snack. At that time the resident stated to the DON who provided the snack, "get me out of here." The resident's statement was not directly acknowledged instead s/he was told to stay and have the snack. Interview with the DON on 3/26/15 at 8:25 AM revealed the CNAs had been instructed not to assist residents to bed until after everyone was out of the dining room. In addition, she verified staff attempted to keep residents up until at least 7 PM. 3. Review of the quarterly MDS assessment dated 1/5/15 showed resident #8 had diagnoses that included cerebral vascular accident and legal blindness, and required limited one person physical assist for transfers, walking, and dressing. Observation on 3/25/15 at 6:08 PM showed the call light was on outside the	F 242	3) All nursing staff will be inserviced regarding the need to both understand any resident preference or choice and the need to intervene to provide for that resident preference/choice. Staff will be inserviced to read and be familiar with resident care plans to include preference and choice. 4) Monitored by Director of Nursing through quarterly Quality Assurance Reporting of resident preferences/choice are identified in care plan and observation of staff that preferences/choices are being provided.	5/8/15

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F 242	Continued From page 6 resident's room. The resident requested assistance getting ready for bed. CNA #2 responded with "not right now," turned off the call light, and left the room. Further observation at 7:02 PM (54 minutes later) showed the call light illuminated outside the resident's room. At that time, CNA #3 responded. The resident again requested assistance getting ready for bed and at that time was provided assistance.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and medical record review, the facility	F 279	F279 This facility will develop a comprehensive and individualized care plan for all residents. 1) A: Resident #7 has expired but Interdisciplinary Team will use resident chart as training tool and will evaluate documentation regarding incontinence and toileting and review record to determine what would have been most appropriate incontinence care plan for this resident. B: Resident #17 will have 7-day bowel/bladder assessment done. DON will review assessment and individualized bladder schedule will be developed. Incontinence plan will be added to resident Care Plan. 2) Interdisciplinary Team will review all residents care plans and DON will review all resident's charts. Any resident identified with incontinence will result in a new 7 day bowel/bladder assessment. Assessment will be reviewed by DON and individualized bladder schedule will be developed and added to Care Plan.	

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F 279	Continued From page 7 failed to develop a comprehensive and individualized care plan for 2 of 10 sample residents (#7, #17). The findings were: 1. Review of the 1/6/15 quarterly MDS assessment showed resident #7 was occasionally incontinent of urine. Interview with the DON on 3/26/15 at 8:25 AM verified the resident was incontinent of urine. Review of the 3/18/15 care plan showed no evidence a care plan for incontinence was developed. Interview with the DON on 3/26/15 at 8:25 AM verified there was no care plan developed for incontinence. 2. Review of the 1/6/15 quarterly MDS assessment showed resident #17 was frequently incontinent of urine. Review of the 1/7/15 care plan showed no evidence a care plan for incontinence was developed. Interview with the DON on 3/26/15 at 8:25 AM verified there was no care plan developed for incontinence.	F 279	3) DON will ensure every resident will have, upon admission, quarterly, and with significant change, a 7-day bowel and bladder assessment done. Assessment will be reviewed by DON and individualized bladder schedule will be developed and schedule added to Care Plan. All nursing staff will be inserviced to review and follow all resident care plans. 4) Monitored by DON through quarterly Quality Assurance reporting of review of updated resident incontinence care plan.	5/8/15
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff followed the care plan for 1 of 9 sample residents (#19). The findings were: Review of the 3/17/15 quarterly MDS assessment	F 282	F282 This facility will ensure services will be provided in accordance with each resident's written plan of care. 1) Resident #19 will have 7-day bowel/bladder assessment done. Upon completion of assessment, DON will review and evaluate results and develop individualized incontinence care plan. 2) Interdisciplinary Team will review all residents care plans and DON will review all resident's charts. Any resident identified with incontinence will result in a new 7 day bowel/bladder assessment.	

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F 282	Continued From page 8 showed resident #19 was always incontinent of urine and occasionally incontinent of bowel. Further review showed the resident required limited assistance for toileting and personal hygiene. Review of the 3/18/15 care plan showed an intervention for incontinence was "Toileting during the day no less than 2 Q hrs [2 hours]." The following concerns were identified: a. Continuous observation on 3/24/15 from 8 AM to 11:30 AM (3.5 hours) showed the resident was not toileted or offered toileting. b. Continuous observation on 3/25/15 from 5 PM to 7:30 PM (2.5 hours) showed the resident was not toileted or offered toileting. c. Interview with the DON on 3/26/15 at 8:25 AM revealed the care plan should have been followed in regard to toileting the resident no less than every 2 hours.	F 282	Assessment will be reviewed by DON and individualized bladder schedule will be developed and added to Care Plan. 3) DON will ensure every resident will have, upon admission, quarterly, and with significant change, a 7-day bowel and bladder assessment done. Assessment will be reviewed by DON and individualized bladder schedule will be developed and schedule added to Care Plan. All nursing staff will be inserviced to review and follow all resident care plans. 4) Monitored by DON through quarterly Quality Assurance reporting of review of updated resident incontinence care plan.	5/8/15
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, staff interview, and medical record review, the facility failed to ensure the necessary assessments and monitoring was implemented to ensure prevention of potential healthcare complications from congestive heart failure and edema for 1 of 9 sample residents	F 309	F309 This facility will ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 1) Resident #7 has expired, however, DON will use resident #7 record as a CHF training tool for all nursing staff. Specific CHF guidelines of care will be identified to include daily intake and output, daily weights, oxygen saturation every shift, pitting edema evaluation every shift and lung assessments every shift. 2) DON will review diagnoses of all residents. Any resident identified to have a diagnosis of CHF will have CHF monitoring guidelines included in Care Plan	

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F 309	Continued From page 9 (#7). The findings were: Review of the medical record showed resident #7 had diagnoses to include congestive heart failure and edema. Review of the 1/6/15 quarterly MDS assessment showed the resident required extensive assistance for ADLs. Review of the care plan last reviewed on 1/1/15 showed under the category of "Potential for healthcare Complications" interventions included: monitor for edema, dyspnea (shortness of breath) and weight gain. When interviewed on 3/26/15 at 8:25 AM, the DON stated the monitoring would be included in the nursing notes and was not on any other monitoring form or flow sheet. Periodic observations on 3/23/15, 3/24/15, 3/25/15 and 3/26/15 showed the resident's feet and ankles were swollen. However, there was no evidence of assessment or monitoring of the edema in the nursing notes. Interview with the DON on 3/26/15 at 8:25 AM revealed she thought staff were monitoring and assessing the resident but were not documenting their findings.	F 309	3) All nursing staff will be inserviced regarding the need to closely monitor all CHF patients for any signs of exacerbation to include edema, weight gain or respiratory change. Upon identification of any exacerbation immediate interventions to include intake and output, weights, oxygen saturation, edema, and respiratory status will be initiated by nursing staff.. Congestive Heart Failure monitoring guideline policy will be developed and reviewed by all nursing staff. 4) Monitored by DON through quarterly Quality Assurance reporting of CHF resident documentation. 5/8/15	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 This facility will ensure staff provides appropriate treatment and services to restore as much normal bladder function as possible. Resident #7 has expired. 1) Resident #19 will have 7-day bowel/bladder assessment done. Upon completion of assessment, DON will review and evaluate results and develop individualized incontinence care plan. 2) Interdisciplinary Team will review all residents care plans and DON will review all resident's charts.	

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	535019	A. BUILDING _____ B. WING _____	C 03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	300 SOUTH US HWY 20 BASIN, WY 82410

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F 315	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure staff provided the appropriate treatment and services to restore as much normal bladder function as possible for 2 of 6 sample residents (#7, #19) who were incontinent. The findings were: 1. Review of the 3/17/15 quarterly MDS assessment showed resident #19 was always incontinent of urine and occasionally incontinent of bowel. Further review showed the resident required limited assistance for toileting and personal hygiene. Review of the 3/18/15 care plan showed an intervention for incontinence was "Toileting during the day no less than 2 Q hrs [2 hours]." The following concerns were identified: a. Continuous observation on 3/24/15 from 8 AM to 11:30 AM (3.5 hours) showed the resident was not toileted or offered toileting. b. Continuous observation on 3/25/15 from 5 PM to 7:30 PM (2.5 hours) showed the resident was not toileted or offered toileting. c. Interview with the DON on 3/26/15 at 8:25 AM verified the resident should have been toileted no less than every 2 hours. 2. Review of the 1/6/15 quarterly MDS assessment showed resident #7 was occasionally incontinent of urine. Further review showed the resident required extensive assistance with toileting and limited assistance with personal hygiene. Observation on 3/24/15 from 8 AM to 11:30 AM (3.5 hours) showed the resident was not toileted or offered toileting. Review of the care plan showed the resident was identified as incontinent but it was not individualized or specific	F 315	Any resident identified with incontinence will result in a new 7-day bowel/bladder assessment. Assessment will be reviewed by DON and individualized bladder schedule will be developed and added to Care Plan. 3) DON will ensure every resident will have, upon admission, quarterly, and with significant change, a 7-day bowel and bladder assessment done. Assessment will be reviewed by DON and individualized bladder schedule will be developed and schedule added to Care Plan. All nursing staff will be inserviced to review and follow all resident care plans. 4) Monitored by DON through quarterly Quality Assurance reporting of review of updated resident incontinence care plan.	5/8/15

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F 315	Continued From page 11 in regard to a toileting plan or interventions; the care plan just indicated incontinence episodes should be documented. Interview with the DON on 3/26/15 at 8:25 AM verified the care plan was not individualized and that 3.5 hours was "probably" too long to wait between toileting interventions.	F 315		
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, staff interview and review of facility food storage information, the facility failed to ensure a sanitary environment in the kitchen. The findings were: 1. Observation in the kitchen on 3/23/15 at 3:50 PM showed the water filter attached to the ice and water dispenser had a label which showed the date the filter was due to be changed was June 2014. Interview with the maintenance director on 3/24/15 at 9:30 AM verified the filter had not been changed and was overdue. 2. Observation on 3/23/15 at 3:50 PM showed crumbs and debris including what appeared to be	F 371	F371 This facility will ensure food is stored, prepared, distributed and served under sanitary conditions. 1) A. Water filter attached to the ice and water dispenser will be changed buy Maintenance Staff. B: Crumbs and debris underneath shelving in dry food storage area will be immediately removed and area cleaned by Dietary supervisor. Ceiling tiles above food preparation area will be cleaned by Dietary Manager. C: 1. Two unopened plastic containers of fruit salad will be tossed. 2. Opened package of white sliced cheese with no open date will be tossed. 3. Pickle relish located in refrigerator with opened date of 9/23 will be tossed. 2) Kitchen will be thoroughly inspected for any visible signs of dirt, grime or debris. Any visible signs of uncleanliness in the kitchen will result in immediate cleaning by Dietary Manager.	

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BONNIE BLUEJACKET MEMORIAL NURSING HOME	308 SOUTH US HWY 20 BASIN, WY 82410

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F 371	Continued From page 12 rodent droppings underneath the shelving in the dry food storage area. Interview with the dietary manager on 3/25/15 at 10:05 AM verified the debris under the shelving and was not aware of any current rodent problems. In addition, ceiling tiles located above a food preparation area were soiled with dried on splattered food. The condition of the dry storage area and the ceiling tiles remained uncleaned on 3/25/15 at 10:05 AM. 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 on 3/23/15 at 3:50 PM showed the following items with date and labeling concerns: a. In the produce walk-in- refrigerator there were 2 unopened plastic containers of "fruit salad." The containers were original from the producer and included "Best before" dates. One container showed it was best before 2/26/15, and the other best before 3/12/15. b. In another walk-in- refrigerator there was an opened package of white sliced cheese with no date as to when it was opened or as to when it was to be used by. Next to this cheese package was a larger package of yellow cheese slices which were labeled "opened 2/23." Review of the facility's "Use By Date Food Labeling Guide" showed sliced processed cheese was expected to be dated with a use by date of "3 months after opening." c. The refrigerator with the cheese also contained a container of pickle relish which was about 1/3 full. The container was labeled "opened 9/23." Review of the facility's "Use By Date Food Labeling Guide" showed bulk items such as	F 371	All food containers will be checked by Dietary Manager to ensure they have been marked with "open date." Any items noted to not have "open date" will be immediately discarded by Dietary Manager. "Open dates" will be checked by Dietary Manager to ensure Use By Dates are appropriately timed. Any food item identified as being past it's appropriate Use By Date will be immediately discarded by Dietary Manager. 3) A: Dietary Manager will add filter replacement to cleaning schedule to use to remind maintenance staff when filter changes are due. Maintenance Supervisor will add ice machine filter replacement to routine check schedule to ensure filter is changed regularly. B: Dietary Manger will inservice dietary staff about the need to review and perform all tasks on the dietary cleaning schedule including checking under all shelving units for debris. Dietary Manger will add ceiling to cleaning schedule and ceiling will be cleaned regularly. C: Dietary Manager will inservice dietary staff regarding need to review and follow all "Open dates" and "Use by dates" and any food items not containing an "open date" will be immediately discarded and any food items past the "Use by date" will be immediately discarded by staff.	

DR 4/22/15

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F 371	Continued From page 13 pickles were expected to be dated with a use by date of "6 months after opening." According to Food Code 2013, U.S. Public Health Service 3-501.17: "(B) Except as specified in ¶¶ (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety."	F 371	4) Monitored by Dietary Manager through quarterly Quality Assurance reporting of Dietary Manager cleaning schedule reviews and observations of department cleanliness, filter replacement and food container "open date" and use by date." 5/8/15	
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced	F 387	F387 This facility will ensure each resident is seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. 1) 1. Physician will be scheduled to visit resident #8 in April and will provide resident physical exam. 2. Physician will be scheduled to visit resident #9 in April and will provide resident physical exam.	

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F 387	Continued From page 14 by: Based on medical record review and staff interview, the facility failed to ensure residents were seen by a physician every sixty days as required for 5 of 9 sample residents (#7, #8, #9, #18, #19). The findings were: 1. Review of the physician progress note for resident #8 dated 1/20/15 showed the physician documented a 60 day assessment for the resident which included a review of medications, but did not examine the resident. The note showed "Patient is gone away from his/her room right now. S/he is not examined today." The physician progress note dated 3/20/15 showed the physician completed a chart review, but did not examine the resident. The note showed "patient is sleeping today. No exam done." 2. Review of the physician progress note for resident #9 dated 1/20/15 revealed the physician reviewed the resident's chart and labs, but did not examine the resident. The note showed "no exam done today." The physician progress note dated 3/20/15 showed the physician reviewed the resident's chart and labs, but the resident "was not seen today. S/he is not woken up." 3. Review of the 1/20/15 physician progress notes for resident #18 showed the physician documented a 60 day assessment for the resident. The note showed the resident's chart was reviewed; however, the resident was sleeping and was "not woken or disturbed." 4. Review of the physician progress notes for resident #19 dated 11/21/14 and 1/20/15 showed the physician documented a 60 day assessment for the resident. Review of notes for 11/21/14	F 387	3. Physician will be scheduled to visit resident #18 in April and will do physical exam. 4. Physician will be scheduled to visit resident #19 in April and will provide resident physical exam. 5. Resident #7 has expired. Physician called to see resident up decline in health condition. Documentation will be placed in resident chart. 2) Director of Nursing will review all resident charts and any resident identified to have not had a physical exam by physician at last visit will have physician visit scheduled in April, 2015 and physical exam provided by physician. 3) medical Staff will be inserviced by Administrator regarding need to provide physical exam of each resident at each scheduled visit. 4) Monitored by Director of Nursing through quarterly Quality Assurance reporting of physician visit physical exam review.	5/8/15

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F 387	Continued From page 15 showed "No exam was done." Review of the 1/20/15 notes showed "No exam performed." 5. Review of the physician progress notes for resident #7 dated 1/20/15 showed the physician documented a 60 day assessment for the resident. The physician spoke with the resident, however, review of these notes showed "EXAM: Not performed." Further review of the progress notes showed no rationale as to why the exam was not performed during the physician's visit. 6. Interview with the DON on 3/26/15 at 8:30 AM verified residents were not usually awakened if sleeping when the physician made a visit.	F 387		
F 411 SS=B	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the dental agreement, the facility failed to ensure	F 411	F411 This facility will provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident. 1) Administrator will identify and contract with a dentist to meet the needs of routine and emergency dental services for residents. Administrator will develop emergency dental service policy. 2) Director of Nursing will ensure each resident has preferred dentist identified on file to ensure best possible routine and emergency dental services are available for each resident. 3) Administrator will inservice Medical Staff regarding emergency dental service policy to ensure process understanding.	

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F 411	Continued From page 16 emergency dental services were available for residents. The findings were: Review of the dental agreement showed routine services would be provided, however, there was no provision for emergency dental services. Interview with the administrator on 3/26/15 at 9:15 AM verified the consulting dentist was not local and would not be available to provide emergency dental services.	F 411	Administrator will provide copy of emergency dental policy to contracted emergency dentist. DON will inservice nursing staff regarding emergency dental service policy. 4) Monitored by DON through quarterly Quality Assurance reporting of routine and emergency dental care of all residents.	5/8/15