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

PRINTED: 07/10/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the incident report, the facility failed to immediately notify the physician or family of an accident resulting in	F 157	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and Stat law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 42 C.F.R. Par 488.18 and section 7317A of the State Operations Manual. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.	6-25-09

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

Admin 7-20-09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollo 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 ays owing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 448011 Facility ID: WY0016 If continuation sheet Page 1 of 36

RECEIVED
Wyoming Dept of Health
AUG 18 2009
Office of Healthcare Licensing and Surveys

Accepted w/ Changes (typed) & Re-submitted by Kelly Rose, NHA
8/24/09

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F 157	Continued From page 1 injury for 1 of 15 sample residents (#33). The findings were: On 6/24/09 at 6:20 PM, observation revealed resident #33 had an open area on the top of each of the three middle toes on the left foot. At 6:45 PM that day, the director of nursing (DON) stated the wounds were "rug burns." Review of the incident report, completed on 6/25/09 as a late entry, showed the injury occurred in April 2009. The report documented that neither the family nor the physician were notified of this April injury until 6/4/09. At 5:50 PM on 6/25/09 the DON confirmed the incident report was correct.	F 157	Resident #33: Family and MD have been notified 6/25/09. All other residents will be reviewed to ensure family & MD is aware of changes. The facility will notify family & MD of all changes and conditions of residents care according to established guidelines. All changes of condition will be reported in morning briefing. Staff will be questioned during morning briefing as to family & physician notification. In-service to all staff done 8-14-09. Audits to inform family & physician will be done 5x weekly in A.M. Briefing & reported quarterly to Q.A.	8-14-09
F 174 SS=E	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interviews with residents and staff, the facility failed to enhance the quality of life for residents by enabling them to independently make and receive private telephone calls. During a confidential meeting, 5 of 6 residents stated they could not access a private telephone for personal calls, and two residents (#8, #43) were observed to either receive or make personal calls at the nurses' station. The findings were: During a confidential meeting on 6/23/09 at 4 PM, five residents stated they did not have access to a private telephone for personal calls. The residents stated there was not a cordless phone in the facility and that calls were made or received from	F 174	F174 The resident will have the right to have reasonable access to the use of a telephone where calls can be made without being overheard. A cordless phone has been purchased for residents. The phone in the men's lounge has been changed. It is a one line phone and is user friendly and has been untangled. The residents have the right to have reasonable access to the use of a telephone where calls can be made without being overheard. In-service & educate residents during resident council. Reported quarterly to Q.A.	7-15-09 8-12-09

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F 174	Continued From page 2 the nurses' station or from someone's office. Observation on 6/23/09 at 3:35 PM showed resident #8 was attempting to hold a private conversation from the phone at the nurses' station where 3 staff members were talking, and a surveyor was reviewing medical records. At 5:05 PM that evening, observation showed a land line phone in one of the lounge areas. A sign posted on the wall indicated the phone was for resident use. However, the cord was tangled and the phone could not be brought to ear level. In addition, there was no dial tone. During the observation, the business office manager walked in and stated one of the buttons for lines 1 through 4 had to be pushed before the phone was operable. She acknowledged that the posted sign did not indicate this instruction and that residents would probably not know how to access an outside line. The manager also stated there was no cordless phone in the facility. During an observation on 6/24/09 at 7:15 PM resident #43 approached the administrator and DON with piece of paper containing a number for a personal call. The administrator took the resident to the nurses' station in order to place the call.	F 174		
F 244 SS=E	483.15(c)(6) PARTICIPATION IN RESIDENT & FAMILY GROUPS When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 244	The facility will listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	8-12-09

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F 244	Continued From page 3 interviews, review of the resident council minutes, and test tray results, the facility failed to address a grievance presented during 2 of 4 resident council meetings since January 2009. The findings were: During a confidential group interview on 6/23/09 at 4 PM, six residents stated the food was bland and needed more spices. They further stated the issue of adding additional spices to the condiments on the tables had previously been brought up in the resident council meetings. Review of the council minutes showed the council specifically requested additional spices at the January and May 2009 meetings. Further review of the January minutes revealed the dietary manager "was working on" obtaining additional spices. However, observation of the breakfast meal on 6/23/09 and of the evening meal on 6/24/09 showed the only condiments on the tables were salt and pepper shakers and individual sugar and artificial sweetener packets. On 6/24/09 at 4:50 PM, the activity director stated those condiments had always been on the tables. A sample meal was tested on 6/24/09 at 5:56 PM and revealed the peas with minced onion, potatoes, and polish sausage were lukewarm and bland tasting. On 6/25/09 at 9 AM the dietary manager confirmed the council's request had not been addressed.	F 244	Facility has placed more condiments on resident tables. We will review resident council minutes from this date forward to make sure resident requests are being addressed. Resident council minutes from Jan. will be reviewed to determine grievances and recommendations of family have been acted on. A copy of all resident council minutes will be given to all dept. heads. Any issues voiced will have a written plan of action completed with a copy given to the resident council and administrator. In-service to all department heads by Administrator on 8-12-09. Follow up by Administrator one week after Resident Council. Quarterly Report to Q.A.	8-12-09
F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 250	The facility will maintain medically related social services to attain the highest practicable physical, mental & psychosocial well being of each resident. Residents' 37, 10, 8, 22, & 23 have had mental status, geriatric depression scales and anxiety scales completed.	

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F 250	Continued From page 4 by: Based on observation, staff interview, and medical record review, the facility failed to ensure social services were provided according to the needs of 5 of 14 sample residents (#8, #10, #22, #23, #37). The findings were: 1. Observation on 6/22/09 at 2:45 PM and at 3:45 PM showed resident #37 conversing with family and staff. Interview with the resident on 6/23/09 at 4 PM and on 6/24/09 at 10:25 AM revealed the resident was alert and oriented and conversed appropriately. Review of the 2/2/09 quarterly and 4/14/09 significant change Minimum Data Set (MDS) assessments showed the resident could communicate without difficulty. Review of the Mental Status Questionnaire, Geriatric Depression Scale (GDS), and Zunig Anxiety Scale, all completed on 2/2/09, showed they were blank with "Unable to answer" written across the bottom of each page. Review of social services documentation dated 2/4/09 showed the resident stated s/he was happy at the facility and enjoyed playing cards and other activities. 2. Observation on 6/23/09 at 6:10 AM and at 8:16 AM showed resident #10 was alert, oriented to self and conversed appropriately with staff. Review of the 3/30/09 MDS assessment showed the resident began expressing unrealistic fears and displaying sad, pained, worried facial expressions. Review of the Zunig Anxiety Scale, GDS, and the Mental Status Questionnaire, all completed on 4/8/09, showed each was blank with the comment, "Unable to answer," handwritten at the bottom of the page. Review of the entire record showed no evidence of further attempts at evaluating this resident.	F 250	Residents' #37, 10, 8, 22 & 23 will have a mini-mental, depression screen & anxiety scale done. The remaining residents will be reviewed to ensure social services were provided according to needs & that assessments are complete and accurate. The new Social Services Director (SSD)will train with an experienced SSD. This will be audited weekly by MDS coordinator & reported quarterly to QA.	8-1-09 8-1-09

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F 250	Continued From page 5 3. Review of the 12/10/08 initial and the 3/12/09 Minimum Data Set (MDS) assessments for resident #8 revealed s/he was usually able to understand and to be understood. Observation on 6/22/09 at 5:35 PM and again at 9:05 PM revealed the resident spoke to a resident in the dining room appropriately. In addition observation on 6/22/09 at 9:05 PM revealed the resident spoke with the surveyor and was sometimes appropriate in his/her statements and at times seemed to be confused. Review of the social service progress notes dated 12/3/08 showed the resident was unable to take the "social service tests," which were identified as the Geriatric Depression Scale (short form), the Zung Anxiety Scale and the Mental Status Questionnaire. Review of these test forms dated 12/10/08, 3/18/09 and 6/17/09 revealed the resident was "unable to answer questions" was documented on each form. 4. Review of the 9/24/08 initial, and the 12/20/08 and 4/1/09 MDS assessments for resident #22 showed s/he was able to understand and be understood. Observation on 6/22/09 at 8:20 PM revealed the resident conversed briefly, but appropriately. However, review of the three "social service tests" dated 9/22/08 and 3/25/09 all were blank with, "Unable to answer questions," written at the bottom of the forms. Review of the 4/15/09 social services quarterly/annual progress notes showed the resident had a "sad look about [him/her] all the time" since returning from the hospital. Review of the medical record showed no evidence the resident's sadness was evaluated or assessed for causative or contributing factors and possible interventions. 5. Review of the 5/7/09 initial MDS assessment	F 250		

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F 250	Continued From page 6 for resident #23 showed the resident understood others and was able to be understood. Review of the three social service tests dated 5/18/09, were blank and documented the resident was "unable to answer questions." 6. During an interview with the social services' director on 6/25/09 at 12 noon, it was revealed that no other attempts to evaluate the residents had been made. Additionally, the director stated she was unaware of any evaluation tools that could be used with cognitively impaired residents.	F 250		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272		

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F 272	Continued From page 7 Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure a comprehensive assessment was performed in a variety of areas for 4 of 15 sample residents (#12, #22, #24, #31). The findings were: 1. According to physician's orders, resident #12 received four laxatives daily for a diagnosis of constipation. Review of the 3/11/09 significant change Minimum Data Set (MDS) assessment documented the resident was incontinent of bowel. Review of the "Bowel and Bladder Evaluation" dated 3/11/09 showed "yes/no" answers were circled. However, an analysis of the resident's bowel status related to laxative usage and constipation was lacking. On 6/25/09 at 8:15 AM the director of nursing confirmed the assessment was not comprehensive. 2. Review of the 1/2/09 MDS assessment for resident #24 showed identified concerns for mood state, cognitive loss/dementia, behavior symptoms, and psychotropic drug use. Review of the RAP (resident assessment protocol) for these areas revealed the comprehensive assessments did not address the causative or contributing factors for the problems identified. 3. Review of the 6/6/09 significant change MDS assessment for resident #31 showed the resident	F 272	The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Resident #12 has had a Bowel and Bladder Evaluation. Resident #24 – Significant change has been done with comprehensive assessments. Resident #31 has had comprehensive assessments, cognitive loss/dementia & delirium. Resident #22 has had cognitive loss, psychosocial mood. New RN, MDS Coordinator and new Social Services Director will address problem areas identified. MDS coordinator will review all medical records weekly to ensure Raps are complete and comprehensive at admission and annually. This audit will be reported quarterly to Q.A. 8/12/09	8-21-09

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F 272	Continued From page 8 triggered for cognitive loss/dementia and delirium. Review of the RAPs showed the assessments were not comprehensive and failed to address the causative and contributing factors, for the problem areas identified. 4. Review of the 4/09 initial MDS assessment for resident #22 revealed the resident triggered for cognitive loss/dementia, mood state, and psychosocial well-being. Review of the RAPS for these areas showed the assessments were not comprehensive as they did not addresses the causative and contributing factors for the problems identified.	F 272	Resident #10 – Significant change done.	7-22-09.
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change assessment for 1 of 6 residents (#10) who had experienced a significant	F 274	The facility will conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. Nursing will notify DON & MDS coordinator of any significant change of condition. MDS coordinator will schedule a significant change in condition MDS assessment if indicated. Educate, random QA & quarterly reports to QA by DON or designee.	8-21-09

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F 274	Continued From page 9 change. The findings were: Comparison of a significant change Minimum Data Set (MDS) assessment completed on 1/2/09 with a quarterly MDS assessment completed on 3/30/09 showed that by 3/29/09 (the assessment reference date) resident #10 declined from requiring extensive assistance to needing total assistance with transfers, ambulation in the room and corridor, bathing, and toilet use. The quarterly assessment also showed the resident improved in the ability to perform personal hygiene. However, a significant change assessment was not completed. Interview with the DON on 6/25/09 at 8:36 AM confirmed a significant change assessment had not been done.	F 274	Significant changes may be identified in morning briefing. In-service to all staff on 8-14-09. Q.A. audits done 5x weekly during briefing by DON or designee. Quarterly report to Q.A.	8-14-09
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	The assessment will accurately reflect resident status. A RN will conduct or coordinate each assessment with the appropriate participation of health professionals. The RN, MDS Coordinator will sign and certify that the MDS assessment is complete. For residents #10, 12 and 37. Comprehensive assessments will be completed according to the ARD dates as determined by the MDS coordinator.	8-15-09

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F 278	Continued From page 10 resident assessment is subject to a civil money penalty of not more than $6,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure assessments were completed accurately or coordinated as required for 3 of 14 sample residents (#10, #12, #37). The findings were: 1. The comprehensive activity assessment completed for the 1/2/09 significant change MDS assessment for resident #10 was dated 1/16/09. Section VB2 of that assessment was dated 1/9/09. According to the Centers For Medicare & Medicaid Services (CMS) Revised Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 2.0, "The comprehensive RAI is considered complete on the date the RN Coordinator indicates completion of the RAPs (VB2)." 2. Review of the comprehensive assessment information for the 3/11/09 MDS significant change assessment for resident #12 revealed the following concerns: a. The assessments for pressure sores, falls, and psychotropic medications were completed on 4/2/09. b. The psychosocial well-being and nutritional status assessments were completed on 3/27/09. c. The activities of daily living functional/rehabilitation potential and urinary	F 278	Resident #12 had a full MDS completed	8-12-09.

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F 278	Continued From page 11 incontinence assessments were dated 3/25/09. On 6/25/09 at 8:28 AM the DON confirmed the assessment dates. Review of Section V showed the V82 date was 3/11/09. According to the CMS Revised Long-Term Care Facility RAI User's Manual, Version 2.0, "The comprehensive RAI is considered complete on the date the RN Coordinator indicates completion of the RAPs (V82)." 3. According to the quarterly MDS assessment dated 2/2/09, resident #37 improved in ambulation in the room and hall, personal hygiene, range of motion, toilet use, and urinary incontinence. However, the section indicating the resident's overall condition was documented as "No change." In addition, review of the 4/14/09 significant change MDS assessment showed the resident demonstrated improvement in bed mobility, transfers, ambulation, and balance. For this assessment, Section Q2 was marked by staff as "deteriorated." On 6/25/09 at 8:30 AM the DON confirmed the inaccuracies.	F 278	Resident #10 has had an activity assessment. Residents #12 assessment pressure sores, falls, and psychotropic meds. Resident #37 – full MDS assessment completed 7/13/09. In-service, educate & QA. MDS coordinator will QA each chart & report to DON weekly. In-service given 8-12-09 on accuracy of dates. In-service on accuracy of assessments scheduled 8-19-09. MDS coordinator will monitor weekly & report quarterly to Q.A.	8-19-09
F 279 SS=D	483.20(d), 483.20(k)(1) 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	F 279	The facility will use results of assessment to develop, review and revise the resident's comprehensive plan of care. Care plans will be developed, reviewed and revised based on assessments.	

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F 279	Continued From page 12 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 medical record review and staff interview, the facility failed to develop and implement a comprehensive care plan for 1 of 14 sample residents (#39). The findings were: Review of nursing documentation dated 6/5/09 at 5 PM showed the physician notified staff that resident #39 had a fractured wrist. Review of the current care plan showed interventions to protect the wrist had not been developed. On 6/25/09 at 6:44 PM, the DON reviewed the care plan and verified interventions related to the fracture were lacking.	F 279	Resident #39 – Care Plan has been updated include treatment of fractured wrist. In-service, QA & education by 8/21/09. Staff Development Coordinator, MDS Coordinator, Dietary, Activity & Social Services Director on care planning. In-service on care plans scheduled 8-19-09. Completion of care plans will be monitored weekly by MDS coordinator & reported quarterly to Q.A.	8-8-09 8-19-09
F 281 SS=F	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure nursing assessments were completed by a registered nurse as required by the state of Wyoming for 14 of 14 sample residents (#4, #8, #10, #12, #15, #22, #23, #24, #31, #32, #33, #36, #37, #39) who required comprehensive nursing assessments. In	F 281		

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F 281	Continued From page 13 addition, the facility failed to ensure staff followed professional standards of practice in regard to following physician orders for 2 of 14 sample residents (#4, #22), in regard to following nursing standards of practice for one of 14 sample residents (#9) and finally, in regard to following national dietary standards of practice for 1 of 14 sample residents (#37). The findings were: In regard to performing nursing assessments: Review of the Wyoming State Board of Nursing's publications, specifically Chapter III of the July 2005 "Nursing Practice Act" and November 2003 "Administrative Rules and Regulations" showed: Section 3. Standards of Nursing Practice for the Licensed Practical Nurse (a) Standards related to the licensed practical nurse's contribution to the nursing process. (1) The licensed practical nurse shall: (A) Contribute to the nursing assessment by: (I) Collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes: (1.) Observation about the condition or change in condition of the client; (2.) Signs and symptoms of deviation from normal health status. Failure to follow this standard of practice was identified for 14 of 14 sample residents (#4, #8, #10, #12, #15, #22, #23, #24, #31, #32, #33, #36, #37, #39) who required comprehensive assessments in areas that were completed by the nursing department. During an interview on 6/24/09 at 4:15 PM, the DON stated she was aware licensed practical nurses (LPNs) could not assess residents in the State of Wyoming. On	F 281	The services provided or arranged by the facility will meet professional standards of quality. All will have care plans reviewed and signed by RN by 8/21/09. Physician orders will be followed (Residents #4, 22, 9 and 37) Restorative will document on flow sheet daily during the week. Nurses will complete treatment on weekends. In-service on care plans scheduled 8-19-09. Completion of assessments will be monitored weekly by MDS coordinator & reported quarterly to Q.A.	8-21-09

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F 281	Continued From page 14 6/25/09 at 8:30 AM the DON stated the LPN who was previously doing comprehensive assessments in nursing areas had been doing so for a year. She had no explanation as to why this occurred. In regard to not following physician orders and standards of practice: 1. Review of the physician's orders for resident #22 showed an order dated 3/31/09 for the anti-hypertensive Metoprolol, twice daily. Additional instructions for the administration of this medication revealed it should not be given if the systolic blood pressure reading was less than 100 or if the pulse was less than 55. The following concerns were identified: a. Review of the May 2009 medication administration record (MAR) revealed no evidence staff took a blood pressure reading prior to the morning dose on 17 of 31 days. In addition, there was no evidence the resident's pulse was counted prior to the 7 AM dosing on 30 of 31 days. b. Review of the June 2009 MAR showed the pulse was not taken on any day from 6/1/09 through 6/24/09 prior to the 7 AM dosing. 2. Review of the physician's orders dated 1/27/09 for resident #4 showed an order for Jobst pumps [an elastic garment to prevent or control edema in the lower legs] bilaterally for one hour every day on Monday through Friday and for thirty minutes on Saturday and Sunday. Observation on 6/22/09 from 2:30 PM through 9:20 PM revealed the Jobst pumps were not applied. Interview with certified nurse aide (CNA) #1 on 6/25/09 at 3 PM revealed she was unaware of the order for Jobst pumps. Interview with the DON on 6/24/09 at 1:30 PM	F 281	Blood pressure and pulse for resident #22 will be completed prior to administration of metoprolol per physician's orders and hold if indicated. Jobst pumps will be used for Resident #4 according to physician orders. Night Charge Nurse will review documentation daily and notify DON of concerns. In-service following physicians orders was done on 8-6-09. DON or designee will review documentation daily. Report to Q.A. quarterly.	8-6-09

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F 281	Continued From page 15 revealed she thought the order was no longer valid. However, review of physician's orders showed no evidence the order had been discontinued. In addition, there was an order written on the same day for TED hose (anti-thrombolytic stockings) to be worn in the morning and removed at bedtime. Observation on 6/22/09 at 7:40 PM, when the resident was assisted to bed for the night, showed the TED hose were not removed. Interview with CNA #1 on 6/25/09 at 3 PM revealed she was unaware the TED hose were to be removed at bedtime. 3. According to the Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, page 3-6, nursing must function under the direction of a licensed physician. In regard to not following nursing standards of practice: On 6/23/09 at 7:10 AM observation showed the DON prepared and administered medications to resident #9. Reconciliation of the medications with the physician's orders showed the resident should have also received Requip 2.5 milligrams. At 9:45 AM that day the DON confirmed she did not administer Requip to the resident. After checking with the physician, at 1:25 PM that afternoon the DON stated the medication was discontinued when the resident was readmitted to the facility on 5/15/09. However, on 5/26/09 the physician signed the May 2009 recapitulation of orders which was reviewed by nursing on 5/1/09 and included the order for Requip. The 5/26/09 order would have superceded the one dated 5/15/09. The DON stated the order should have	F 281	Resident #9. Order has been corrected 7/15/09.	

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F 281	Continued From page 16 been clarified, but confirmed it was not. According to the sixth edition of "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell, and Martin, 2004, if an order is "questionable for any reason, the physician must be notified for clarification." In regard to not following national dietary standards of practice; Review of the 4/14/09 significant change Minimum Data Set (MDS) assessment showed resident #37 required a comprehensive assessment of his/her nutritional status. Review of information listed by the facility as the comprehensive assessment showed it was completed by the dietary manager. On 6/23/09 at 11:30 AM, the dietary manager confirmed she completed that assessment. The dietary manager also stated the registered dietitian (RD) was in the facility every week. However, the manager stated she completed the Resident Assessment Protocol summaries [comprehensive assessments] if the registered dietitian would not be in the facility before the RAP deadline. According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals...for nutrition risk factors, ..It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care	F 281	MDS coordinator will monitor to ensure assessments are completed in a timely manner. Resident #37 was discharged 7-12-09. Nursing In-service on following nursing standards of practice and clarification of orders is scheduled 8-17-09. In-service on appropriate staff to complete comprehensive assessments will be given to registered dietitian & dietary manager & care plan team on 8-14-09. MDS coordinator will monitor weekly & report quarterly to Q.A.	8-17-09

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F 281	Continued From page 17 Process. Further, the 2008 Standards of Practice specifically state: "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients."	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS 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 2 of 14 sample residents (#4, #22). The findings were: 1. Review of the 1/20/09 care plan for resident #4 showed the resident should wear a figure eight brace for posture correction during meal times. Observation of the 6/22/09 and 6/24/09 evening meals showed the resident did not wear the brace. Please refer to F 281 regarding the failure to utilize Jobst pumps as care planned for this resident. 2. Review of the care plan updated on 10/8/08 for resident #22 showed staff should put socks on the resident's feet at night. Observation on 6/22/09 at 8:20 PM when the resident was assisted to bed for the night showed staff did not put socks on the resident. Interview with CNA #1 on 6/25/09 at 3 PM revealed she was unaware	F 282	The service provided by the facility by qualified persons in accordance with each resident's written plan of care. The care plan for resident #4 has been reviewed & corrected regarding the figure 8 brace. See F281 RT Jobst pump. PT evaluation ordered to re-evaluate & re-fit brace. 8-10-09 Resident #22 gets socks on at night. Care plan has been reviewed & corrected. All staff in-serviced. 8-12-09 In-service to CNA's on 8-8-09. In-service to charge nurses on 8-12-09. Daily monitoring & quarterly report to Q.A.	

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F 282	Continued From page 18 the resident needed socks placed on his/her feet at bedtime.	F 282		
F 309 SS=D	483.25 QUALITY OF CARE 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 acute respiratory symptoms were assessed and treated in a timely manner for 1 of 1 sample resident (#32) who had congestion and wheezing. In addition, the facility failed to ensure staff provided the necessary care and services for 1 of 1 sample resident (#33) who had rug burns on top of the toes. The findings were: 1. Review of resident #32's medical record revealed a nursing note dated 5/1/09 at 1 PM, which documented the resident was congested, with expiratory wheezes. Review of a nursing note of 5/2/09 at 1 AM revealed the physician was faxed regarding the congestion, wheezes, and the resident's increased combative behaviors. The information regarding the resident's signs and symptoms of acute illness was faxed on a Saturday morning. The following concerns were identified: a. The physician did not respond to the faxed information until 5/6/09, five days after onset of symptoms, when he visited the resident. There	F 309	Each resident will receive and the facility will 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. Resident #32 will be seen by her personal physician. Acute illnesses will not be faxed to physicians. Acute illnesses will be called to physicians to ensure notification. Acute illnesses will be reported in morning briefing and followed up daily as needed until resolved.	7-28-09

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F 309	Continued From page 19 were no orders written to address the resident's respiratory signs and symptoms. b. There were no follow-up assessments of the symptoms. The next nursing notes were written on 5/6/09 at 4 PM and only documented that the physician had been in to see the resident. 2. On 6/24/09 at 6:20 PM, observation showed resident #33 had an open area on the top of each of the three middle toes on the left foot. At 6:45 PM that day, the DON stated the wounds were rug burns that occurred in April 2009. Failure to provide the necessary and timely care and services was identified as follows: a. According to the nursing notes dated 6/1/09, staff documented the resident's toes were "reddened around scabs, slightly warm to touch." b. Further review of nursing documentation showed no evidence the physician had been notified until 6/4/09. Interview with the DON on 6/25/09 at 5:50 PM confirmed the 6/14/09 date was correct. c. After notification of the resident's condition, the physician ordered an X-ray of the resident's toes. She also ordered ice and elevation of the left foot, four times daily for fifteen minutes each time. On 6/8/09 the physician ordered an antibiotic for redness of the toes. d. It was unclear from the record or interview with the DON why the report to the physician was delayed.	F 309	The facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental & psychosocial well-being in accordance with the comprehensive assessment and plan of care. Resident #33's physician was notified of wounds to top of toes on 6-14-09. Acute illnesses will be followed up 5 days weekly in morning briefing by DON or designee. Quarterly report to Q.A.	8-12-09 8-12-09
F 314 SS=E	483.25(c) 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	F 314		

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F 314	Continued From page 20 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, staff interview, interview with a physical therapist, and review of therapy notes, the facility failed to establish and implement a wound care program to consistently document wound information, provide treatment to promote healing, prevent infections, and prevent development of new wounds. 5 of 5 sample residents (#1, #12, #33, #37, #39) had open wounds or tissue injuries; all of them lacked consistent, accurate, documentation related to their wound care. The findings were: Medical record review revealed residents #1, #12, #33, #37, and #39 had a history of open wounds or tissue injury. Observation during the dates of survey showed the areas on all the residents except resident #33 were healed. The areas on resident #33 were improving. The following concerns with failure to establish and implement an effective wound care program were identified: a. Accurate, consistent documentation in the medical record related to (or pictures showing) size, depth, and appearance of each wound was missing. At 8:10 PM on 6/24/09, the DON confirmed wound documentation had not been completed for all the residents. b. Documentation related to the effectiveness of the current treatment was absent. c. A physical therapist came weekly to make "wound rounds." However, interview with the physical therapist on 6/25/09 at 10:23 AM	F 314	The facility will 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. A wound care team has been established. It consists of nursing, MDS coordinator, dietary and DON and PT per consult. Resident #1 is now resident #31. Resident #12, 37 and 39 have been documented on as wounds healed and had a complete skin assessment. Resident #33 has accurate measurements in weekly skin reports. MDS & nursing will assess accurately, measure all wounds weekly. Wound team will meet to discuss appropriate interventions & provide treatment to promote healing, prevent infections and prevent development of new wounds. Assessments to be reviewed by wound team weekly. In-service MDS & nursing, dietary & DON. Quarterly report to Q.A.	8-12-09

This was confirmed as an error by OHS - Dues made in document - this one was missed. Res #1 = Res #31

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(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)	COMPLETION DATE
F 314	Continued From page 21 revealed she did not provide treatments to wounds; she worked in an advisory capacity. The therapist stated she made rounds with nursing staff if someone was available; if staff were busy, she went alone, but did not document her measurements or observations in the medical records. The therapist also stated she did not see residents if nursing staff reported the wounds were improving. She wrote recommendations for the physicians, but if they weren't signed off as orders, they were not carried out. d. Review of the therapist's notes showed she documented the date she was in the facility and which residents she saw. However, there was no information pertaining to wounds or tissue injuries. e. The facility was unable to provide evidence of a formalized, evidence-based protocol for wound care.	F 314	Resident #31 has a history of open wounds, but no current skin issues. Resident #37 was discharged 7-21-09. Resident #12 had a skin assessment & has no current issues. Resident #39 has weekly skin assessments by wound care team. Weekly QA by nursing & MDS nurse reported weekly to DON & quarterly to QA.	7-13-09 7-21-09 7-13-09 7-13-09 DOC 8/11/09
F 356 SS=B	483.30(a) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	The facility will post the following information on a daily basis at the beginning of each shift; Facility name, current date, total # and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. RN's, LPN's, CNA's, and resident census. DON will instruct charge nurses to document actual hours worked. This information will be kept for 18 months.	8-4-09

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F 356	Continued From page 22 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to complete the nurse staff posting at the beginning of each shift during 4 of 4 days of survey. The findings were: On 6/22/09 at 12:45 PM, observation revealed the nurse staff posting, dated 6/22/09, had all three shifts posted for the day. Observations on 6/23/09, 6/24/09, and 6/25/09 revealed all three shifts were again posted once each day for the entire day. During an interview with the DON on 6/25/09 at 5:40 PM, it was revealed that the night nurse routinely posted the entire nurse staffing information on one document for all shifts..	F 356	Daily audit by DON & reported quarterly to QA.	8-12-09
F 368 SS=E	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.	F 368	Each resident will receive & the facility provides at least 3 meals daily at regular times comparable to normal meal times in the community.	

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F 368	Continued From page 23 The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, confidential resident interviews, and review of the resident council minutes, the facility failed to ensure snacks were offered each evening to all residents. The census at the time of the survey was 41. The findings were: During confidential interviews on 6/23/09 at 4 PM, six residents stated snacks were not always offered each evening. Review of resident council minutes showed the issue was discussed with the facility during the January and May 2009 meetings. Observation from 2:30 PM until 9:20 PM on 6/22/09 revealed no snacks were provided or offered to any residents.	F 368	Snacks will be offered daily at bed time to all residents. In-service dietary & nursing. Review snack service at resident council for needs being met and types of snacks desired, etc. A resident roster will be delivered with the h.s. snacks. CNA's will document A=for Accepted, R=for Refused. This roster will be reviewed by dietary manager weekly & reported to QA quarterly.	8-18-09 8-12-09
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The facility will store, prepare, distribute & serve food under sanitary conditions. The walk-in refrigerator has been defrosted & cleaned. Standing water on the shelves below condenser has been removed & food items are no longer stored under condenser. Defrost walk-in refrigerator has been added to weekly cleaning schedule.	8-12-09

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F 371	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to prevent food from exposure to possible contamination while in refrigerated storage. The findings were: Observation on 6/22/09 at 3:30 PM, 6/23/09 at 11:15 AM and again on 6/24/09 at 1:23 PM revealed the following concerns: There was a one inch thick sheet of clear ice which covered one quarter of the surface area of the condenser in the walk-in refrigerator. Observation also revealed standing water on the shelves below the condenser. A tray of food items, including individual servings of juices, eggs, V8 and tomato juice, milk containers, food supplements (Boost, Activa), and chocolate syrup, were stored on one of the shelved below the condenser.	F 371	In-service to dietary by 8-19-09. Weekly audits of cleaning compliance will be done by dietary manager & will be reported quarterly to QA.	8-19-09
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS 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 by: Based on record review and staff interview, the facility failed to ensure physician's visits were	F 387	The residents will be seen by a physician once every 30 days for first 90 days after admit & every 60 days thereafter.	

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F 387	Continued From page 25 made every sixty days as required for 3 of 14 (#10, #24, #32) sample residents. The findings were: 1. Review of the physician's notes for resident #24 revealed the resident was seen by the physician on 9/8/08, on 12/17/08 (100 days) and again on 5/6/09 (139). Interview with the DON on 6/25/09 at 3:45 PM revealed the resident's physician only worked part-time and said if he was not reminded to come every sixty days, he would not come. 2. Review of the physician's notes for resident #32 revealed the resident was seen by a physician on 9/8/08, on 12/17/08 (100 days) and again on 5/6/09 (139 days). Interview with the DON on 6/25/09 at 3:45 PM revealed the resident's physician only worked part-time and said if he was not reminded to come every sixty days, he would not come. 3. Review of physician's documentation showed resident #10 was seen by a physician on 9/8/08, 12/17/08, and 5/6/09. Review of nursing notes and physician's orders provided no evidence the resident was seen at any other time. On 6/25/09 at 8:35 AM, the DON stated she checked with the physician who confirmed he had not seen the resident every 60 days as required.	F 387	Residents #10, 24 & 32 will be seen by physician on 7-28-09. All other residents have been audited for timely physician visits. Medical records will keep a log of Dr. Visits and report the beginning of each month to DON or designee. Educate, random QA & quarterly report. MHCC & physicians will be notified of this deficiency and the need for their cooperation and prompt participation in seeing their residents according to state regulations. In-service will be done for medical records. Monthly audits will be done by medical records & reported to DON. Quarterly reports to QA.	7-28-09 8-12-09
F 425 SS=E	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		

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F 425	Continued From page 26 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that expired medications on 1 of 2 medication carts were not administered to residents. Additionally, the facility failed to provide secure storage of medications located on 1 of 1 treatment carts. The findings were 1. Observation on 6/25/09 at 2:20 PM revealed a 1000 tablet stock bottle of Vitamin C was 3/4 full; the expiration date on the label was 5/09. At that time, RN #1 confirmed the expiration date and stated the tablets were currently being administered to residents receiving Vitamin C 500 milligrams. 2. Observation throughout the survey showed the clean utility room was looked with a coded keypad, but all staff had the code. Nursing, housekeeping, maintenance, and purchasing staff were seen to enter the room at various times. Observation on 6/25/09 at 1:55 PM showed the treatment cart was stored in the room. The cart	F 425	The facility will provide routine & emergency drugs and biologicals to its residents or obtain them under an agreement described in 483.75 (h) of the part. Vitamin C has been destroyed. Med carts will be checked each month for expired meds by licensed nurse. DON or designee will be asked to review meds on a monthly basis. Meds on treatment cart will be locked in bottom of treatment cart and locked in clean utility room (double locked). All medications will be reviewed monthly for expiration, audits will be reported to DON monthly & to Quality Assurance quarterly. Licensed nurses will be in-serviced by 8-17-09.	8-12-09 8-17-09

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F 425	Continued From page 27 contained the following medications: full and three partially used 1 pound jars of Triamcinolone 0.1% cream, a half full 16-ounce bottle of mineral oil, and 2 boxes of gauze used for Unna Boots. At 2:20 PM that day, registered nurse (RN) #1 verified the medications were not secure.	F 425	Treatment cart will have a lock installed with access only by licensed nursing staff. See page 27.	8-17-09
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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.	F 431	Drugs & biologicals used in the facility will be labeled in accordance with currently accepted professional principles & include the appropriate accessory & cautionary instructions & the expiration date when applicable.	

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F 431	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all medications were labeled with expiration dates. The medication refrigerator and 1 of 2 medication carts contained drugs that lacked expiration dates on the labels. The findings were: 1. On 6/25/09 at 2:30 PM observation revealed a bottle of Amoxicillin suspension for resident # 9 was stored in the medication refrigerator at the nurses' station. The label on the bottle did not have an expiration date. At the time of the observation, RN #1 confirmed the expiration date was lacking. She also stated the medication was only good for a short time period of time as it had to reconstituted. 2. Observation of the medication cart for the Men's hall on 6/25/09 at 2:20 PM showed a 100 ml bottle of Cheratussin for resident #14. The label indicated the date the prescription was filled, but an expiration date for the drug was not included. At the time of the observation, RN #1 verified the label did not have an expiration date.	F 431	Resident #9. Amoxicillin suspension has been discarded. Cheratussin has been destroyed. Meds checked every month for expiration dates. All medications will be reviewed monthly for expiration by licensed nurse. Audits will be reported monthly to DON & quarterly to QA. Licensed nurses will be in-serviced by 8-17-09.	8-17-09
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as	F 441	The facility will establish and maintain an infection control program designed to provide a safe sanitary & comfortable environment & to prevent the development & transmission of diseases & infection.	

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F 441	Continued From page 29 isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff used appropriate infection control practices when they assisted with placing a nasal cannula into 1 of 4 sample residents (#4) who utilized oxygen, and during 1 of 1 observation of the laundry area. The findings were: 1.Observation on 6/22/09 at 3:48 PM revealed the laundry room was located in the basement of the facility. Posted on the door to the laundry room was a sign stating "eye wash station." Inside the laundry room was a large wall-mounted sink. The sink's faucet had two green covered eye washing plumbing attachments. Also attached to the faucet was a three foot flexible hose. Interview with the laundry manager at the time revealed the sink was also used to occasionally wash fecal material from dirty laundry if it was not completely washed out by nursing staff. 2. Observation on 6/22/09 at 7:40 PM revealed certified nurse aide (CNA) #2 assisted resident #4 to bed. She placed soiled clothing on the resident's oxygen nasal cannula, placed the bag of soiled wipes used to cleanse feces from the perineal area on top of the soiled clothing, finished bedtime care, and then placed the unprotected and uncleaned nasal cannula back into the resident's nares. Interview with the CNA at the time of the observation revealed she should have cleaned the cannula with an alcohol swab	F 441	Laundry will not be washed out in eye wash station sink. Plastic bags are taped to each concentrator. Cannulas are placed in the bags when not being used. If cannulas are soiled, they will be replaced. In-service for laundry on proper use of eye wash station. In-service for CNA's on infection control of soiled cannulas. Weekly audit of CNA's & laundry. Quarterly report to QA.	8-18-09

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F 441	Continued From page 30 prior to placing it into the resident's nose. Interview with the infection control coordinator/director of nursing on 6/25/09 at 11:45 AM revealed the nasal cannula should have been cleansed prior to being placed into the resident's nares.	F 441		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff used the wall mounted hand sanitizers properly during 3 of 3 random observations. The findings were: 1. On 6/22/09 at 7:40 PM observation revealed certified nurse aide (CNA) #1 assisted resident #4 from the wheelchair to the bedside commode where the resident was found to be incontinent of feces. CNA #1 provided perineal care, removed her gloves, and used the wall- mounted hand sanitizer to cleanse her hands. Observation of the hand sanitizing process revealed the CNA placed her hand on the top of the sanitizer then quickly hit the top of the dispenser. The liquid splashed onto the back of the dispenser. The foam sanitizer then fell to the floor with minimal, if any, of the sanitizer falling into the CNA's hands. A second observation at 7:50 PM revealed the CNA again used the same process to clean her hands after providing catheter care. Finally, after the CNA completed bedtime care, she again used the	F 444	The facility will require staff to wash their hands with each direct resident contact for which hand washing is indicated by accepted professional practice. All staff will be educated on proper use of wall mounted hand sanitizers. Random observations of staff will be done weekly & reported to DON monthly. Quarterly reports to QA.	8-12-09

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F 444	Continued From page 31 same process when she left the room. Interview with CNA #1 on 6/25/09 at 3 PM revealed she did not know why she used the dispenser in that manner. 2. Observation of the evening meal on 6/24/09 revealed CNA #2 used the same hand sanitizing process as noted above by CNA #1, after delivering a meal tray to one resident and prior to delivering a meal tray to another resident. During an interview with the infection control nurse/director of nursing on 6/25/09 at 11:45 AM, she stated the CNAs did not properly use the dispenser. Interview with the staff development coordinator on 6/25/09 at 9:50 AM revealed there had been no in-service provided on the proper use of the wall-mounted unit. 3. On 6/24/09 at 7:12 PM the DON was observed using a hand hygiene dispenser to obtain foam to cleanse her hands. The DON pushed the trigger mechanism with the heel of her hand while holding her fingers in an upward position. Instead of foam releasing into the fingers and palm, it squirted onto the back of the dispenser and ran down the surface of the unit. Interview with the staff development coordinator on 6/25/09 at 9:50 AM revealed she had not educated staff on the proper way to use the dispensers. She stated she was unaware staff were not using the correct amount of product.	F 444	The facility will provide or obtain lab services to meet the needs of its residents.	
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES 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.	F 502	F502 The facility will provide or obtain lab services to meet the needs of its residents. Resident #1 has had TSH done. Resident #4 has had BMP done. Resident #31 has had Free T4. Resident #37 has had BMP done – discharged.	7-1-09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER	1108 BIRCH STREET DOUGLAS, WY 82633

(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 502	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain timely laboratory services for 4 of 14 sample residents (#1, #4, #31, #37). The findings were: 1. Review of the 1/29/09 physician's orders for resident #1 revealed an order for a thyroid stimulating hormone (TSH) test. Review of the medical record revealed a TSH had not been performed as of 6/25/09. Interview with the (DON) on 6/25/09 at 3:45 PM, confirmed the test had not been done. 2. Review of the 2/24/09 physician's orders for resident #4 showed an order for a basic metabolic panel (BMP) test to be performed. Review of the medical record revealed, as of 6/25/09, the BMP had not been done. Interview with the DON on 6/25/09 at 3:45 PM, she stated the test was not performed. 3. Review of the 2/24/09 physician's orders for resident #31 revealed an order for a Free T4 (Thyroxine) test. Review of the medical record showed that, as of 6/25/09 the test was not performed. Interview with the DON on 6/25/09 at 3:45 PM, confirmed the test was not done. 4. According to the June 2009 orders, resident #37 was to have a BMP test done every 3 months, and it was due on 6/3/09. Review of laboratory tests filed in the record showed the results were not included. Interview with the DON on 6/24/09 at 12:30 PM revealed the last test was done on 3/18/09. On 6/25/09 at 8:36 AM, the DON verified the test had not been done as	F 502	Lab work will be scheduled as ordered and Central Supply will review schedule Mon thru Fri for completion and notify nursing if lab results have not been received. Educate, random QA & report quarterly to QA committee. The facility will file in the residents clinical record lab reports that are dated & contain the name & address of the testing lab. Resident #37 has had the CS test results placed in chart. The clerk copy for Central Service to follow up. CS will ensure it has been faxed to us & is in the chart.	7-1-09 8-12-09 8-13-09

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 502	Continued From page 33 ordered.	F 502		
F 507 SS=D	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory (lab) test results were filed in the medical record for 1 of 14 sample residents (#37). The findings were: Review of lab test results showed a urine test was performed for resident #37 on 1/29/09. The test was indicative of a urinary tract infection and a culture and sensitivity (C&S) test was completed. The C&S test results showed the specimen was contaminated, and on 1/30/09 at 10:40 AM an RN at the facility was notified and a new specimen would be collected. Review of all filed laboratory test results showed none from a new specimen. On 6/24/09 at 12:30 PM the DON was able to show the results from the repeat C&S from the January order. She stated the test results had just been faxed to the facility.	F 507	Refer to F502 for details regarding lab.	8-13-09
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		

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F 520	Continued From page 34 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of facility documents, the facility failed to ensure the quality assurance performance improvement (QAPI) program was effective in identifying and resolving concerns with resident care. The findings were: 1. Interview with the administrator and DON on 6/24/09 at 11 AM revealed problems were identified on a "look and listen" basis with no specific indicators identified to monitor, track, and trend care processes. 2. Refer to F281 for specific information regarding staff not following physician's orders for residents #4 and #22, in regard to not following standards of nursing practice for resident #9, and finally, for not following dietary standards of practice for	F 520	F520 (Page 35) The facility will maintain a quarterly assessment & assurance committee consisting of DON, physician designated by facility to at least 3 other members of the facility staff. Indicators identified by this survey through risk management, through QA meetings & resident issues will be integrated into the QA program. Topics to be included: wound care, lab, infection control & IIS stucks. Audits will be done by department heads, DON & Administrator or their designee. There will be random observations, questions and return demonstrations used as audit tools. All audits will be in writing and completed.	8-21-09

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F 520	Continued From page 35 resident #37. 3. Refer to F314 for details regarding the failure of the facility to establish and implement a wound care program to consistently document wound information, provide treatment to promote healing, prevent infections, and prevent development of new wounds for residents #1, #12, #33, #37, and #39. 4. Refer to F502 for specific information regarding laboratory orders not being followed as ordered for residents #4, #31, and #37.	F 520	Weekly or monthly as indicated. They will be reported at quarterly QA meetings. For the remainder of the 2009 calendar year, QA will meet monthly to assure compliance & standards of practice are met. Identifiers can be identified by this survey, risk management, QA meetings, recurring issues, pharmacy meetings & therapy meetings, & through resident, family or staff concerns & in morning briefing.	8-21-09