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

PRINTED: 08/20/2015
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
	535022	A. BUILDING _____ B. WING _____	C 08/06/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 medical record review and staff interview, the facility failed to notify the physician for 1 of 5 residents (#119) with a change in	F 157	F 157 Correction for cited residents 09/20/15 8/28/15 Resident #119 Chart review conducted for dates beyond those reviewed by survey team. 07/22/15 demonstrated one episode of blood glucose did not include documentation of intervention or provider notification. All subsequent blood glucose documentation was completed in a timely manner with documentation and provider notification if appropriate. Resident had end stage renal failure and expired on 08/3/15. Survey occurred on 08/5/15. Identification of other residents will occur by: All residents have the potential to be affected by assessment, intervention and reevaluation of abnormal assessment findings. Diabetic residents with bedside glucose monitoring are at high risk for abnormal lab findings. Systemic Corrective Action: 1. Develop tool/report to audit documentation of residents with abnormal bedside glucose values for assessment, intervention and reevaluation documentation and appropriate provider notification. 2. Conduct nursing education related to documentation, nursing process and provider notification. First phase education for LPN, RN and Medication Aides completed 08/13/15. Content included assessment, intervention, reevaluation, and documentation and provider notification. Education on collaboration and communication among the healthcare team and resident plan of care education completed 08/13/15 for all staff at Pioneer Manor. 3. To assure sustainability, a Phase 2 education program reinforcing above topics as well as delegation and scope of practice will be completed by January 1, 2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8/24/15

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
AUG 25 2015
Healthcare Licensing and Surveys

8/28/15 - Plan of Correction accepted with agreed to changes. Spoke with Jonni Belden at 3:30 pm. Date of correction is 8/28/15. Jaeen VanDyke, RN

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F 157	Continued From page 1 clinical status. The findings were: Review of the 6/14/15 quarterly MDS assessment for resident #119 showed the resident had diagnoses that included diabetes mellitus. Review of the 7/10/15 physician progress note showed "...We will go ahead and continue to do Accu-Cheks [blood glucose testing] b.i.d. [twice daily] before meals..." Review of physician orders showed an order dated 7/11/15 for "Blood glucose evaluation BID [twice daily]." The following concerns were identified: a. Review of the 7/21/15, timed 7:18 AM, nurse's note showed "Reported to this nurse by [another nurse's name] that resident had blood glucose of 34 on sat. 7/18/15, 32 on sun. 7/19/15, 36 on mon. 7/20/15, then [his/her] blood sugar was 38 this am." b. Review of the recorded blood glucose evaluations for the dates of 7/18/15, 7/19/15, and 7/20/15 did not show any such low blood glucose measurements. c. Further review of the medical record failed to show any evidence the resident's physician was contacted regarding low blood glucose levels on the dates of 7/18/15, 7/19/15/ and 7/20/15. d. Interview with the resident's physician on 8/6/15 at 3:35 PM confirmed she had not been notified of the resident's low blood sugars, and would expect to be notified of low blood sugars. e. Interview with the administrator and DON on 8/6/15 at 4:45 PM confirmed the facility's expectation that low blood glucose measurements, and any interventions taken to treat the low blood glucose, would be documented and the physician notified.	F 157	F157 continued Outcome: 98% of residents with abnormal bedside glucose values will have documentation reflecting assessment, intervention and reevaluation and provider notification. DON or designee will collect data from record audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported quarterly at long term care quality meetings with action plans as appropriate.	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 2 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, and family and staff interview, the facility failed to provide care that met professional standards of quality for 2 of 14 sample residents (#111, #119) receiving nursing care. This failure resulted in resident #111 becoming unresponsive and being transported to the emergency room. The findings were: 1. Review of the 8/1/15 hospital history and physical showed resident #111 had end-stage COPD (chronic obstructive pulmonary disease), and had been admitted to the skilled nursing facility for rehabilitation following hip surgery. Review of the facility 7/31/15 admission evaluation, timed 3:15 PM, showed the resident had respiratory symptoms that included difficulty clearing secretions, shortness of breath at rest and with exertion, and difficulty coughing. Respiratory effort was noted to be labored. The resident's temperature was normal at 98.6 degrees Fahrenheit, and his/her oxygen saturation was recorded as 88% while receiving 4 liters per minute of supplemental oxygen via a nasal cannula. The following concerns were identified: a. Review of the 8/1/15 physical examination, timed 4:01 AM, showed the resident was short of breath with rest and exertion, and was noted to be using accessory muscles to breathe. Review of the 8/1/15 oxygen saturation check, timed 4 AM, showed the resident's oxygen saturation was recorded as 92% while receiving 4 liters per	F 281	F 281 Correction for cited residents 09/20/15 Resident #111 Resident transferred to the hospital for care and subsequently discharged home with family on hospice 08/10/15. Resident on Hospice care in the Close to Home Hospice prior to admission to the nursing home. Thorough record review, discussion with staff and corrective action plan developed to provide care that meets professional standards of quality. Resident #119 Chart review conducted for dates beyond those reviewed by survey team. 07/22/15 demonstrated one episode of blood glucose did not include documentation of intervention or provider notification. All subsequent blood glucose documentation was completed in a timely manner with documentation and provider notification if appropriate. Resident had end stage renal failure and expired on 08/3/15. Survey occurred on 08/5/15. Identification of other residents will occur by: All residents have the potential to be affected by incomplete assessment, intervention and reevaluation of abnormal assessment findings. Diabetic residents with bedside glucose monitoring are at high risk for abnormal lab findings. All residents have the potential to be affected by incomplete assessment, intervention and reevaluation of abnormal assessment findings. Oxygen dependent residents are at high risk for abnormal assessment findings.	8/28/15

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F 281	Continued From page 3 minute of supplemental oxygen. b. Further review of the 8/1/15 hospital history and physical showed the resident's family came to visit at 7:30 AM the morning of 8/1/15 and found the resident seated in a chair with his/her supplemental oxygen turned off. S/he was "...unresponsive and had some shaking movements similar to what patient's family described as a seizure. [His/Her] oxygen was quite low and because of that, [s/he] was transferred back over to the emergency room..." c. Interview with a family member on 8/3/15 at 10:12 AM revealed when family arrived to visit the resident at 7:30 AM on 8/1/15, the resident was unresponsive and "convulsing." The family asked the nurse at the nurses' station for assistance and the nurse did not come to assess the resident. Further, the family member stated the nurse was asked for assistance three times, and the nurse did not come to assess the resident until family called for an ambulance. d. Review of the medical record showed no nursing assessment was completed on the resident on 8/1/15 before transfer documentation timed at 8 AM. The transfer documentation showed the resident had an elevated temperature of 101 degrees Fahrenheit, and his/her oxygen saturation was recorded as 86%. Interview with the administrator and DON on 8/6/15 at 5:40 PM confirmed the resident's supplemental oxygen had been turned off, and revealed the facility did not know if the oxygen saturation charted on 8/1/15 at 8 AM as 86% was taken before or after the resident's supplemental oxygen was turned back on. e. Further interview with the administrator and DON on 8/6/15 at 5:40 PM confirmed the nurse on duty the morning of 8/1/15 failed to go to the resident's room and assess him/her after the	F 281	F 281 continued Systemic Corrective Action: 1. Develop tool/report to audit documentation of residents with abnormal bedside glucose values for assessment, intervention and reevaluation documentation and appropriate provider notification. 2. Develop tool/ report to audit documentation of residents with abnormal SaO2 values for assessment, intervention and reevaluation documentation and provider notification. 3. Conduct nursing education related to documentation, nursing process and provider notification. First phase education for LPN, RN and Medication Aides completed 08/13/15. Content included assessment, intervention, reevaluation, and documentation and provider notification. Education on collaboration and communication among the healthcare team and resident plan of care education completed 08/13/15 for all staff at Pioneer Manor. 4. To assure sustainability, a Phase 2 education program reinforcing above topics as well as delegation and scope of practice will be completed by January 1, 2016. Outcome: 98% of residents with abnormal bedside glucose values will have documentation reflecting assessment, intervention and reevaluation and provider notification. DON or designee will collect data from record audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported quarterly at long term care quality meetings. 98% of residents with abnormal SaO2 values will have documentation reflecting assessment, intervention and reevaluation and provider notification. DON or designee will collect data from record audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported quarterly at long term care quality meetings.	

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F 281	Continued From page 4 family reported to the nurse that the resident was in distress and confirmed the facility expectation in such circumstances would be the nurse would immediately perform a head-to-toe assessment of the resident and make a determination of resident needs. f. Interview with the resident's physician on 8/6/15 at 4 PM revealed the resident "had no lung capacity" and would become hypoxic without supplemental oxygen. g. Further review of the 8/1/15 hospital history and physical showed the resident had a "possible seizure event and this could be related to hypoxia. The patient was hypoxic when they found [him/her] and [his/her] oxygen was not turned on and certainly that could be a contributing factor." Additionally, the resident was found to have elevated troponin levels, indicative of a non-ST elevation myocardial infarction (a type of heart attack). 2. Review of the 5/14/15 quarterly MDS assessment for resident #119 showed the resident had diagnoses that included diabetes mellitus. Review of the 7/10/15 physician progress note showed "...We will go ahead and continue to do Accu-Cheks [blood glucose testing] b.i.d. [twice daily] before meals..." Review of physician orders showed an order dated 7/11/15 for "Blood glucose evaluation BID [twice daily]." The following concerns were identified: a. Review of the 7/21/15, timed 7:18 AM, nurse's note showed "Reported to this nurse by [another nurse's name] that resident had blood glucose of 34 on sat. 7/18/15, 32 on sun. 7/19/15, 36 on mon. 7/20/15, then [his/her] blood sugar was 38 this am." b. Review of the recorded blood glucose evaluations for the dates of 7/18/15, 7/19/15, and	F 281		

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F 281	Continued From page 5 7/20/15 did not show any such low blood glucose measurements. c. Further review of the medical record failed to show any evidence the resident's physician was contacted regarding low blood glucose levels on the dates of 7/18/15, 7/19/15/ and 7/20/15. d. Interview with the resident's physician on 8/6/15 at 3:35 PM confirmed she had not been notified of the resident's low blood sugars, and would expect to be notified of low blood sugars. e. Interview with the administrator and DON on 8/6/15 at 4:45 PM confirmed the facility's expectation that low blood glucose measurements, and any interventions taken to treat the low blood glucose, would be documented and the physician notified.	F 281		
F 309 SS=G	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 medical record review and family and staff interview, the facility failed to provide necessary care to maintain the highest practicable well-being for 1 of 5 sample residents with a change in condition (#111). This failure resulted in the resident becoming unresponsive and returning to the hospital. The findings were:	F 309		

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F 309	Continued From page 6 Review of the 8/1/15 hospital history and physical showed resident #111 had end-stage COPD (chronic obstructive pulmonary disease), and had been admitted to the skilled nursing facility for rehabilitation following hip surgery. Review of the facility 7/31/15 admission evaluation, timed 3:15 PM, showed the resident had respiratory symptoms that included difficulty clearing secretions, shortness of breath at rest and with exertion, and difficulty coughing. Respiratory effort was noted to be labored. The resident's temperature was normal at 98.6 degrees Fahrenheit, and his/her oxygen saturation was recorded as 88% while receiving 4 liters per minute of supplemental oxygen via a nasal cannula. Review of the 8/1/15 physical examination, timed 4:01 AM, showed the resident was short of breath with rest and exertion, and was noted to be using accessory muscles to breathe. Review of the 8/1/15 oxygen saturation check, timed 4 AM, showed the resident's oxygen saturation was recorded as 92% while receiving 4 liters per minute of supplemental oxygen. Further review of the 8/1/15 hospital history and physical showed the resident's family came to visit at 7:30 AM the morning of 8/1/15 and found the resident seated in a chair with his/her supplemental oxygen turned off. S/he was "...unresponsive and had some shaking movements similar to what patient's family described as a seizure. [His/Her] oxygen was quite low and because of that, [s/he] was transferred back over to the emergency room..." Interview with a family member on 8/3/15 at 10:12 AM revealed when family arrived to visit the	F 309	F 309 Correction for cited residents Resident #111 Resident transferred to the hospital for care and subsequently discharged home with family on hospice 08/10/15. Resident on Hospice care in the Close to Home Hospice prior to admission to the nursing home. Thorough record review, discussion with staff and corrective action plan developed to provide care that meets professional standards of quality. Identification of other residents will occur by: All residents have the potential to be affected by incomplete documentation of assessment, intervention and reevaluation of abnormal assessment findings. Oxygen dependent residents are at high risk for abnormal assessment findings. Systemic Corrective Action: 1. Develop tool/ report to audit documentation of residents with abnormal SaO2 values for assessment, intervention and reevaluation, documentation and provider notification. 2. Conduct nursing education related to documentation, nursing process and provider notification. First phase education for LPN, RN and Medication Aides completed 08/13/15. Content included assessment, intervention, reevaluation, and documentation and provider notification. Education on collaboration and communication among the healthcare team and resident plan of care education completed 08/13/15 for all staff at Pioneer Manor. 3. To assure sustainability, a Phase 2 education program reinforcing above topics as well as delegation and scope of practice will be completed by January 1, 2016. 4. Develop report for unplanned transfers and analyze for performance improvement opportunities.	09/20/15 8/28/15

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F 309	Continued From page 7 resident at 7:30 AM on 8/1/15, the resident was unresponsive and "convulsing." The family asked the nurse at the nurse's station for assistance and the nurse did not come to assess the resident. Further, the family member stated the nurse was asked for assistance three times, and the nurse did not come to assess the resident until family called for an ambulance. Review of the medical record showed no nursing assessment was completed on the resident on 8/1/15 before transfer documentation timed at 8 AM. The transfer documentation showed the resident had a temperature of 101 degrees Fahrenheit, and his/her oxygen saturation was recorded as 86%. Interview with the administrator and DON on 8/6/15 at 5:40 PM confirmed the resident's supplemental oxygen had been turned off, and revealed the facility did not know if the oxygen saturation charted on 8/1/15 at 8 AM as 86% was taken before or after the resident's supplemental oxygen was turned back on. Further interview with the administrator and DON on 8/6/15 at 5:40 PM confirmed the nurse on duty the morning of 8/1/15 failed to go to the resident's room and assess him/her after the family reported to the nurse that the resident was in distress and confirmed the facility expectation in such circumstances would be the nurse would immediately perform a head-to-toe assessment of the resident and make a determination of resident needs. Interview with the resident's physician on 8/6/15 at 4 PM revealed the resident "had no lung capacity" and would become hypoxic without supplemental oxygen.	F 309	F 309 continued Outcome: 1. 98% of residents with unplanned transfers will have documentation reflecting assessment, intervention, reevaluation and provider notification. DON or designee will collect data from record audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated and reported quarterly at long term care quality meetings. 2. 98% of residents with abnormal SaO2 values will have documentation reflecting assessment, intervention and reevaluation and provider notification. DON or designee will collect data from record audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported quarterly at long term care quality meetings.	

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F 309	Continued From page 8 Further review of the 8/1/15 hospital history and physical showed the resident had a "possible seizure event and this could be related to hypoxia. The patient was hypoxic when they found [him/her] and [his/her] oxygen was not turned on and certainly that could be a contributing factor." Additionally, the resident was found to have elevated troponin levels, indicative of a non-ST elevation myocardial infarction (a type of heart attack).	F 309	F514 Correction for cited residents Resident #119 Chart review conducted for dates beyond those reviewed by survey team. 07/22/15 demonstrated one episode of blood glucose did not include documentation of intervention or provider notification. All subsequent blood glucose documentation was completed in a timely manner with documentation and provider notification if appropriate. Resident had end stage renal failure and expired on 08/3/15. Survey occurred on 08/5/15.	09/20/15 8/28/15
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain accurately documented medical records for 1 of 14 sample residents (#119). The findings were: Review of the 5/14/16 quarterly MDS assessment showed resident #119 had diagnoses that included diabetes mellitus. Review of the 7/10/15	F 514	Identification of other residents will occur by: All residents have the potential to be affected by incomplete documentation of assessment, intervention and reevaluation of abnormal assessment findings. Diabetic residents with bedside glucose monitoring are at high risk for abnormal lab findings. Systemic Corrective Action: 1. Develop tool/ report to audit documentation of residents with abnormal SaO2 values for assessment, intervention and reevaluation, documentation and provider notification. 2. Conduct nursing education related to documentation, nursing process and provider notification. First phase education for LPN, RN and Medication Aides completed 08/13/15. Content included assessment, intervention, reevaluation, and documentation and provider notification. Education on collaboration and communication among the healthcare team and resident plan of care education 08/13/15 for all staff at Pioneer Manor. 3. To assure sustainability, a Phase 2 education program reinforcing above topics as well as delegation and scope of practice will be completed by January 1, 2016.	

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PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

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F 514	Continued From page 9 physician progress note showed "...We will go ahead and continue to do Accu-Cheks [blood glucose testing] b.i.d. [twice daily] before meals..." Review of physician orders showed an order dated 7/11/15 for "Blood glucose evaluation BID [twice daily]." The following concerns were identified: a. Review of the 7/21/15, timed 7:18 AM, nurse's note showed "Reported to this nurse by [another nurse's name] that resident had blood glucose of 34 on sat. 7/18/15, 32 on sun. 7/19/15, 36 on mon. 7/20/15, then [his/her] blood sugar was 38 this am." b. Review of the recorded blood glucose evaluations for the dates of 7/18/15, 7/19/15, and 7/20/15 did not show any such low blood glucose measurements. c. Interview with the administrator and DON on 8/6/15 at 4:45 PM confirmed the facility's expectation that low blood glucose measurements, and any interventions taken to treat the low blood glucose, would be documented.	F 514	F514 Outcome: 98% of residents with abnormal bedside glucose values will have documentation reflecting assessment, intervention and reevaluation and provider notification. DON or designee will collect data from record audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated and reported quarterly at long term care quality meetings	