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 09/28/2009

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 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain privacy for 1 of 6 sample residents (#112) who was observed while receiving care. The findings were: 1. Observation on 9/25/09 at 9:35 AM showed two	F 164	F164 The resident has the right to personal privacy and confidentiality of his or her personal and clinical record this will be accomplished by: Resident #112 A.) Policies, processes, and orientation are in place for direct care staff in order to protect personal privacy. Disciplinary actions with education were completed with the 3 involved staff members. Leadership team will audit performance of all employees during day to day routine and intervene immediately with corrective action. B.) All residents have the potential to be affected. Leadership team will audit performance of all employees during day to day routine and intervene immediately with corrective action. C.) 10/16/09 a written reminder for all staff regarding personal privacy was posted in the data room, all nursing stations and time clocks. Reminder was given to other department heads to post/distribute to their employees. Immediate intervention with corrective action as appropriate for any outliers. Education, accountability and daily	11/11/09 9/10/07

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

Administrator 10-22-09

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RECEIVED
Wyoming Dept of Health

OCT 22 2009

Office of Healthcare Licensing and Surveys

11/3/09 15 pm POC accepted with date of compliance 11/11/09 per telephone call with Administrator Karla Hobbs

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

PRINTED: 10/12/2009
FORM APPROVED
OMB NO. 0938-0391

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F 164	Continued From page 1 certified nursing assistants (CNAs) were providing incontinence care for non-sample resident #112. The CNAs had closed the door prior to starting care, but the curtain was open. The resident's buttocks were exposed when, without knocking and waiting for permission to enter, registered nurse #5 opened the door and entered the room.	F 164		
F 166 SS=E	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interviews, review of grievance information, and interview with a resident advocate, the facility failed to thoroughly investigate and address grievances for 4 of 4 residents and/or families (#71, #91, #110, #118) who had filed grievances with the facility. The findings were: 1. Interview with a resident advocate on 9/23/09 at 8:52 AM revealed the family of sample resident #110 had expressed multiple concerns in writing to the facility and to the resident advocate. These concerns had been addressed in the care plan conference dated 9/8/09, but the family was still upset as the planned interventions were not being implemented. Review of the interdisciplinary notes from that care conference revealed staff were to "ask and toilet" the resident, insert the lower dentures as they were all the resident had to enable chewing, take the resident to activities by saying such words as "it's time to go" instead of asking if s/he would like to attend, apply	F 166	F166 The resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This will be accomplished by: A.) Policies, processes, and orientation are in place for direct care staff regarding resolution of grievances. Concerns for all listed residents have been addressed with documentation. Resident #110 Care plan was reviewed and updated on 10/14/09. The following actions have been taken to ensure care: o Dentures: The nurse supervisor had spoken to the daughter on 7/29/09 about the poor fit of the resident's dentures. She called the daughter on 10/14/09 to confirm what the family was going to do about the ill fitting dentures so that the resident would be willing to wear them. Daughter stated "It was useless to line bottom dentures as she has lost her top dentures."	11/11/09

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F 166	Continued From page 2 cosmetics, and put the resident's glasses on him/her. Observation on 9/24/09 from 7:50 AM until 12:25 PM showed the above listed activities were not implemented. Refer to F282 for additional details related to failure to follow the care plan and F315 for details of the facility's failure to promote urinary continence. Review of grievance information showed no previous grievance had been logged prior to the start of the survey on 9/23/09. 2. During an interview on 9/24/09 at 8:20 PM, a family member of resident #118 stated the family members had expressed numerous concerns to the facility's administration, both verbally and in writing. The family member stated a response was never received from anyone. S/he also stated that interventions would be determined at the care plan conference meetings, but they were never implemented. Finally, the family member stated s/he called the facility administration and was told a response had not been sent as they thought the family was angry with a specific individual. 3. An anonymous family member was interviewed on 9/25/09 at 12:10 PM. S/he summarized an incident from June 2009 in which the resident was about to be administered an injection of insulin in the main dining room before the family member intervened and informed the nurse the resident was not diabetic and did not need insulin. The family member stated the nurse was confused about the resident's identity. The family member complained to the director of nursing (DON) that same afternoon and, according to the interviewee, received no feedback. A second follow-up with the DON in July 2009 was stated to be equally unproductive.	F 166	F166 Cont. from page 2: o Glasses: The resident often claims these are not her glasses and declines to wear them. Staff was educated on the need to continue to offer glasses and clearly document any refusal. o Bathing and Shampoo: A new bath schedule has been created with specific day and time for bathing. Nursing is monitoring for completion of bathing per schedule on a daily basis. o Toileting: Resident is to be taken to the toilet in morning, before and after meals, mid-after noon, bed-time and upon request per care plan. The staff that did not complete cares as directed by the care plan have been disciplined and re-educated. o Activities: Activity Staff have been re-educated to use a more firm approach and to re-approach resident for next scheduled activity. Since this resident often declines to attend activities because she is afraid visitors won't find her, activity staff has been instructed to assure her they will make sure any visitors find her. o Cosmetics: Care plan updated to include application of cosmetics as resident allows.	

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F 166	Continued From page 3 Review of the resident's medical record on 9/25/09 at 1:45 PM confirmed the lack of a diagnosis or history of diabetes and the absence of a physician's order for insulin. The administrator stated in interview on 9/25/09 at 3:30 PM there was no evidence of a complaint or grievance related to the potential medical error reported by the family member. 4. During an interview on 9/23/09 at 7:53 PM, non-sample resident #91 complained of only receiving one bath per week for most of September 2009. The resident stated s/he was supposed to receive two baths per week and kept track of the number on the room calender. The resident further stated s/he had verbally complained multiple times to the administration, but nothing had ever been done to resolve the problem. 5. On 9/25/09 at 4:20 PM, the administrator confirmed the written grievances were not entered into the system. He stated they had either been handled by staff or "filtered out."	F 166	F166 Cont. from page 3 Evaluation: Reporting to the Quality committee will occur monthly by Social Services staff.	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure 1 of 6 sample residents (#22) was treated with dignity and respect. The findings were:	F 241	F241 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will be accomplished by: Resident #22 A.) Policies, processes, and orientation are in place for staff regarding resident respect and dignity.	11/11/09

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F 241	Continued From page 4 Certified nursing assistant (CNA) #2 and an unidentified housekeeper were observed to enter the room of resident #22 on 9/25/09 at 9:10 AM; the two staff members neither knocked, identified themselves, nor asked permission to enter. The two employees were engaged in a private conversation and did not ask the resident for permission to enter the room; the resident was sitting in bed with his/her eyes open. The housekeeper talked with CNA #2 for another two minutes and then left the room; she did not perform any cleaning tasks or other work in the room. Only after the housekeeper left did the CNA address the resident, telling him/her it was "...time to get up." On 9/25/09 at 2:39 PM, the DON stated it has always been the expectation that staff knock before entering a resident's room.	F 241	F241 Cont. from page 4 Disciplinary actions with education were completed with CNA #2 and housekeeper. Leadership will monitor all staff during day to day routine and intervene immediately as indicated. B.) All residents have the potential to be affected. Leadership will monitor during day to day routine and intervene immediately as indicated. On 10-16-09 a written reminder for nursing staff regarding personal privacy was posted in the data room, all nursing stations and time clocks. Information was given to all department heads to post/distribute to their employees with documentation of receipt by 11-11-09 to DON. Ancillary staff (chaplains, volunteers, abiders) will be provided the same information with documentation of receipt to DON by 11-11-09. Immediate intervention with corrective action as appropriate for any outliers. Education, accountability and daily audits of compliance with providing privacy and confidentiality immediately implemented. C.) Mandatory staff education on Privacy, confidentiality, dignity, resident rights and	
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments as required for 1 of 7 sample residents (#4) who required that assessment. The findings were: Review of the MDS assessments showed the last quarterly assessment for resident #4 was completed on 3/26/09. On 9/25/09 at 4:30 PM, the nurse manager confirmed no assessment had been completed for this resident since 3/26/09.	~~F276~~		

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F 241	Continued From page 4 Certified nursing assistant (CNA) #2 and an unidentified housekeeper were observed to enter the room of resident #22 on 9/25/09 at 9:10 AM; the two staff members neither knocked, identified themselves, nor asked permission to enter. The two employees were engaged in a private conversation and did not ask the resident for permission to enter the room; the resident was sitting in bed with his/her eyes open. The housekeeper talked with CNA #2 for another two minutes and then left the room; she did not perform any cleaning tasks or other work in the room. Only after the housekeeper left did the CNA address the resident, telling him/her it was "...time to get up." On 9/28/09 at 2:39 PM, the DON stated it has always been the expectation that staff knock before entering a resident's room.	F 241	F241 Cont. from page 5 abuse prevention training. Skills stations with competency check list for all staff will be completed by 10/30/09. The above information and skill station content will be part of new employee orientation and annual mandatory education. Immediate intervention with corrective action as appropriate for any outliers. Education, accountability and daily audits of compliance with providing privacy and confidentiality immediately implemented. An audit tool will be developed by 11-11-09 with assignments/schedule to be completed.	
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments as required for 1 of 7 sample residents (#4) who required that assessment. The findings were: Review of the MDS assessments showed the last quarterly assessment for resident #4 was completed on 3/26/09. On 9/25/09 at 4:30 PM, the nurse manager confirmed no assessment had been completed for this resident since 3/26/09.	~~F 276~~	D.) Outcome measure: 100% of residents will have their privacy protected. (knocking, drawing privacy curtain, no personal conversations) Methodology: Random audits by leadership team and education department and direct observation (30 per month) Numerator: # of staff observed respecting resident personal privacy, Denominator: # of observations Evaluation: Nurse Managers will turn in audits weekly to DON until target goals are met then re-evaluate audit form and frequency. Audits/findings will be reports at	

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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 _____	09/28/2009

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

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F 241	Continued From page 4 Certified nursing assistant (CNA) #2 and an unidentified housekeeper were observed to enter the room of resident #22 on 9/25/09 at 9:10 AM; the two staff members neither knocked, identified themselves, nor asked permission to enter. The two employees were engaged in a private conversation and did not ask the resident for permission to enter the room; the resident was sitting in bed with his/her eyes open. The housekeeper talked with CNA #2 for another two minutes and then left the room; she did not perform any cleaning tasks or other work in the room. Only after the housekeeper left did the CNA address the resident, telling him/her it was "...time to get up." On 9/28/09 at 2:39 PM, the DON stated it has always been the expectation that staff knock before entering a resident's room.	F 241	F241 Cont. from page 5 monthly Quality committee meeting by DON or designee	
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete quarterly Minimum Data Set (MDS) assessments as required for 1 of 7 sample residents (#4) who required that assessment. The findings were: Review of the MDS assessments showed the last quarterly assessment for resident #4 was completed on 3/26/09. On 9/25/09 at 4:30 PM, the nurse manager confirmed no assessment had been completed for this resident since 3/26/09.	F 276	F276 The facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This will be accomplished by: Resident #4 A.) The annual MDS assessment for Resident # 4 opened on 10/1/09. The care planning meeting was held on 10/13/09 and the assessment was changed to a significant change MDS. The MDS was completed on 10/14/09. B.) Medical Records completed an audit of all active charts on 10-20-09. Results	11/11/09

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F 276	Continued From page 5 The manager stated it had been "missed."	F 276	F276 Cont. from page 5	
F 281 SS=D	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 medical record review and family and staff interview the facility failed to ensure staff followed professional standards of practice related to clarification and implementation of orders for 1 of 7 sample residents (#118). The findings were: Review of nurses' notes dated 5/26/09 at 4:45 PM showed resident #118 was transferred to the emergency department (ED) for evaluation of a hematoma on the right lower leg. Review of the ED physician's orders, the instructions given to the resident and family, and the nursing notes and medication and treatment records from 5/27/09 to 7/1/09 showed it was unclear whether or not ice or warm moist heat was to be applied to the resident's leg. Review of the medication and treatment orders and the nursing documentation showed neither treatment was implemented correctly. On 9/30/09 at 1:15 PM the DON stated the orders and notes were "confusing." She confirmed there was no evidence either treatment was implemented as ordered. The DON stated the orders should have been clarified. 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."	~~F 281~~	show all MDS were completed as scheduled. Three MDS reports were not on the residents' charts but have been placed as of 10-20-09. C.) A new process for scheduling of MDS will be implemented on 11/1/09. The new process is: The MDS nurses will keep the MDS schedule. They will track when all MDS forms should open and close. The schedule will be sent to the MDS group via e-mail by the MDS nurses. The schedule will include the date and time for the care planning meeting. The Office Specialists will inform the resident and their family of the scheduled care plan meeting based on the information from the MDS nurses. A report from the Accu-Med system will be run weekly as a double check for the MDS schedule. An e-mail will be sent from the Medical Records Coordinator confirming the actual opening of the MDS Departments are responsible to complete their portion of the MDS.	

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F 281 SS=D	The manager stated it had been "missed." 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 medical record review and family and staff interview the facility failed to ensure staff followed professional standards of practice related to clarification and implementation of orders for 1 of 7 sample residents (#118). The findings were: Review of nurses' notes dated 5/26/09 at 4:45 PM showed resident #118 was transferred to the emergency department (ED) for evaluation of a hematoma on the right lower leg. Review of the ED physician's orders, the instructions given to the resident and family, and the nursing notes and medication and treatment records from 5/27/09 to 7/1/09 showed it was unclear whether or not ice or warm moist heat was to be applied to the resident's leg. Review of the medication and treatment orders and the nursing documentation showed neither treatment was implemented correctly. On 9/30/09 at 1:15 PM the DON stated the orders and notes were "confusing." She confirmed there was no evidence either treatment was implemented as ordered. The DON stated the orders should have been clarified. 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."	F 281	F281 Cont. from page 6 Methodology: Medical Record Review Numerator: # of charts with new orders implemented Denominator: # of new orders Evaluation: Nurse Managers will report to DON weekly on data analysis. Data will be reported monthly to the Quality committee by the DON or designee.	

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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, medical record review, and staff interview, the facility failed to ensure the care plan for 2 of 7 sample residents (#110, #118) was implemented as written. The findings were: 1. Refer to F166 for details related to failure to implement interventions from the 9/8/09 care plan conference for resident #110. According to the resident's 9/18/09 care plan, staff were to toilet him/her before and after meals, bathe and shampoo his/her hair twice a week, place the resident's glasses on him/her daily, take the resident to activities as s/he enjoyed them once there, and insert the resident's lower dentures whenever s/he was up. Observation on 9/25/09 from 7:50 AM until 12:25 PM revealed the following concerns: a. Refer to F315 for details related to the lack of toileting. b. Refer to F312 for details related to the lack of bathing and shampooing the resident's hair. c. The resident was observed not to be wearing the lower dentures when eating breakfast in the dining room at 7:50 AM. The resident remained up in a wheelchair from 7:50 AM until after lunch when the observation ceased at 12:25 PM. At no time during this period was the resident noted to be wearing the dentures, nor did staff	F 282	F282 – 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 will be accomplished by: Resident #110 A.) Care plan was reviewed and updated on 10/14/09. The following actions have been taken to ensure care: o Dentures: The nurse supervisor had spoken to the daughter on 7/29/09 about the poor fit of the resident's dentures. She called the daughter on 10/14/09 to confirm what the family was going to do about the ill fitting dentures so that the resident would be willing to wear them. Daughter stated "It was useless to line bottom dentures as she has lost her top dentures." o Glasses: The resident often claims these are not her glasses and declines to wear them. Staff was educated on the need to continue to offer glasses and clearly document any refusal. o Bathing and Shampoo: A new bath schedule has been created with specific day and time for bathing. Nursing is monitoring for completion of bathing per schedule on a daily basis.	11/11/09

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(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 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, medical record review, and staff interview, the facility failed to ensure the care plan for 2 of 7 sample residents (#110, #118) was implemented as written. The findings were: 1. Refer to F166 for details related to failure to implement interventions from the 9/8/09 care plan conference for resident #110. According to the resident's 9/18/09 care plan, staff were to toilet him/her before and after meals, bathe and shampoo his/her hair twice a week, place the resident's glasses on him/her daily, take the resident to activities as s/he enjoyed them once there, and insert the resident's lower dentures whenever s/he was up. Observation on 9/25/09 from 7:50 AM until 12:25 PM revealed the following concerns: a. Refer to F315 for details related to the lack of toileting. b. Refer to F312 for details related to the lack of bathing and shampooing the resident's hair. c. The resident was observed not to be wearing the lower dentures when eating breakfast in the dining room at 7:50 AM. The resident remained up in a wheelchair from 7:50 AM until after lunch when the observation ceased at 12:25 PM. At no time during this period was the resident noted to be wearing the dentures, nor did staff	F 282	F282 Cont. from page 7 C.) A new daily care planning form is being created for better communication of plan to CNA's. It will include all aspects of the care plan. Bath and shampoo: the bath list has been revised and specific dates and times for baths assigned. If a resident refuses a bath the CNA must re-approach. If the resident continues to refuse the CNA must notify the nurse in charge. The nurse will meet with the resident to stress the importance of bathing and encourage the resident to bathe. The nurse will document the outcome of the meeting. The nurse must sign off the CNAs bath list at the end of each shift and the sheet will be given to the nurse manager for auditing. The nurse manager will send the audit forms to the DON weekly. New form developed and implemented by 11-1-09. Activities: Activities staff has been educated on use of a scripted message to encourage resident participation on 10-19-09. They will offer all residents activities and if resident refuses, Activity staff will re-approach for a different activity. The monthly activities sheet for each resident is kept in the activities office. The sheet documents each resident's attendance of activities and includes likes, dislikes and best ways to approach each resident. These activity sheets are put into the resident chart	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535022	A. BUILDING _____ B. WING _____	C 09/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82718

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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, medical record review, and staff interview, the facility failed to ensure the care plan for 2 of 7 sample residents (#110, #118) was implemented as written. The findings were: 1. Refer to F166 for details related to failure to implement interventions from the 9/8/09 care plan conference for resident #110. According to the resident's 9/16/09 care plan, staff were to toilet him/her before and after meals, bathe and shampoo his/her hair twice a week, place the resident's glasses on him/her daily, take the resident to activities as s/he enjoyed them once there, and insert the resident's lower dentures whenever s/he was up. Observation on 9/25/09 from 7:50 AM until 12:25 PM revealed the following concerns: a. Refer to F315 for details related to the lack of toileting. b. Refer to F312 for details related to the lack of bathing and shampooing the resident's hair. c. The resident was observed not to be wearing the lower dentures when eating breakfast in the dining room at 7:50 AM. The resident remained up in a wheelchair from 7:50 AM until after lunch when the observation ceased at 12:25 PM. At no time during this period was the resident noted to be wearing the dentures, nor did staff	F 282	F282 Cont. from page 7 at the end of each month and a new activities sheet started. Revision of activity sheet and work list to be developed and implemented by 11-01-09. Toileting: A bowel and bladder assessment is completed on each resident and the resident's specific plan is entered on their care plan. All direct care staff will be re-educated and demonstrate competency by 10-30-09. Monitoring frequency of toileting as directed by care plan will be completed weekly by Nurse Managers and reported to DON. D.) Outcome measures: 100% of residents will have ADL met Methodology: Medical Record Review Numerator: # of documented baths performed Dominator: # of baths scheduled. Numerator: # of bathing re-approaches documented Denominator: # of bathing refusals documented Numerator: # of resident toileted per care plan	

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F 282	Continued From page 7 attempt to insert them or convince encourage the resident to wear them. d. At 9 AM an activity staff person knelt down beside the resident's wheelchair and asked him/her if s/he wanted to attend the planned activity. When the resident refused, the staff member left without further comment or encouragement in accordance with the care conference notes. e. At no time from 7:50 AM through 12:25 PM was the resident wearing his/her glasses. 2. Refer to F323 for information regarding failure to implement the care plan for resident #118.	F 282	F282 Cont. from page 7 Dominator: # of residents observed Numerator: # of activities resident participated in per care plan Dominator: #of residents reviewed. Numerator: # of activity re-approaches documented Denominator: # of activity refusals documented Evaluation: Nurse Managers will report weekly to DON and results will be reported monthly at Quality committee by DON or designee. Activity measures will be monitored weekly by Activity Coordinator and will be reported monthly at Quality committee.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and review of grievances, the facility failed to assure 6 of 7 sample residents received the necessary staff assistance to complete activities of daily living (ADLs). This failure included lack of personal hygiene with bathing (residents #4, #22, #65, #71, #114) and lack of meal assistance to maintain adequate nutrition (resident #114). In addition, 3 non-sample residents (#16, #91, #119) reported they did not receive baths as they should have. The findings were: As related to lack of bathing:	~~F 312~~		

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F 282	Continued From page 7 attempt to insert them or convince encourage the resident to wear them. d. At 9 AM an activity staff person knelt down beside the resident's wheelchair and asked him/her if s/he wanted to attend the planned activity. When the resident refused, the staff member left without further comment or encouragement in accordance with the care conference notes. e. At no time from 7:50 AM through 12:25 PM was the resident wearing his/her glasses. 2. Refer to F323 for information regarding failure to implement the care plan for resident #118.	F 282		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and review of grievances, the facility failed to assure 6 of 7 sample residents received the necessary staff assistance to complete activities of daily living (ADLs). This failure included lack of personal hygiene with bathing (residents #4, #22, #65, #71, #114) and lack of meal assistance to maintain adequate nutrition (resident #114). In addition, 3 non-sample residents (#16, #91, #119) reported they did not receive baths as they should have. The findings were: As related to lack of bathing:	F 312	F312 – A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by: A.) Resident #4 - Nurse Managers reviewed September bath summary, confirmed that there was no documentation of baths given from September 4-13th and 15th-20th. Resident received 5 baths from September 21st-28th. See organization correction plan below Resident #22 - Nurse Manager reviewed bath schedule, no documentation of bathing noted for 23 days Interviewed staff, reported resident had refused, oral counseling with education provided regarding resident rights and documentation. See organization correction plan below.	11/11/09

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F 312	Continued From page 8 1. The "Comprehensive resident care/bath summary" forms found in resident medical records were reviewed on 9/25/09. For residents #22, #65, and #71, these records revealed extended intervals between documented baths with no refusals noted, including: a. Resident #22 failed to received a bath or shower for 23 days (from 8/23/09 until 9/16/09), 12 days (8/10/09 until 8/23/09), and 7 days (from 7/10/09 until 7/18/09). b. Resident #65 failed to receive a bath for 11 days (from 9/4/09 until 9/16/09). c. Resident #71 did not receive a bath for 7 days (from 9/8/09 until 9/16/09). Interview with registered nurse (RN) #8 on 9/25/09 at 11:05 AM revealed the three residents were in the facility during those periods cited above. She further acknowledged the lapse between baths, stating "...we were busy this summer." The RN added that if residents were offered a bath or shower and refused, the refusal would be documented on the bath form. 2. Review of the 9/16/09 care plan showed resident #4 was to receive a bath or shower and have his/her hair shampooed twice weekly. This intervention was instituted four years ago on 10/11/05. Review of the "Comprehensive resident care/bath summary" forms showed the resident did not receive a bath from 7/12/ through 7/18/09 (7 days) and from 8/24/ through 8/31/09 (8 days). The resident's hair was not shampooed from 7/12/ through 7/26/09 (15 days) nor from 8/24 through 8/31/09. No refusals were documented. 3. According to the "Comprehensive resident care/bath summary" forms, resident #114 did not receive a bath during the 8 day period from 7/23/09 through 7/31/09. The resident refused	F 312	F312 Cont. from page 8 Resident #65 - There is a discrepancy on the 2567 form, there is no # 65 listed on the sample list of residents. See organization correction plan below. Resident #71 - Nurse Managers confirmed that there was no documentation of any baths given from 9-09-09 to 9-15-09, resident received scheduled baths rest of the month. See organization correction plan below. Resident #114 - Resident expired on 9/28/09 Resident #16 - Nurse Manager reviewed September bath summary sheets, confirmed that there was no documentation of baths given from September 9th-15th. On 9-28-09 Nurse manager reviewed bath summary form with resident regarding week of September 19th-documentation noted that Resident #16 had received baths on 9-22-09 & 9-24-09. In August, resident's bath schedule changed from days to evening shift per his request. See organization correction plan below Resident #91 - Nurse Manager reviewed bath schedule, confirmed that resident did not receive baths as scheduled. Counseling with education provided to CNA's. See organization correction plan below	

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F 312	Continued From page 9 several other times, but refusals were not indicated during the above time period. 4. Non-sample residents #91 and #16 stated on 9/23/09 at 7:53 PM and 9/25/09 10:55 AM, respectively, that they did not receive their baths as scheduled. 5. Review of a grievance filed by non-sample resident #119 revealed s/he complained baths were only given once a week. In response to the complaint, RN #1 submitted a written statement citing insufficient staffing as an obstacle to bathing residents more than once a week. 6. The director of nursing stated her expectation, in an interview on 9/25/09 at 2:45 PM, that residents receive a bath or shower at least twice a week. As related to lack of meal assistance: During an observation on 9/25/09 at 10:08 AM, registered nurse (RN) #5 stated the resident was no longer eating independently. The RN further stated she would try to sit with the resident at lunch to encourage meal consumption. Observation at 11:20 AM showed the resident's meal had been uncovered and placed on the overbed table. The resident was sleeping, the meal was untouched, and no staff were present in the room. At no time from 11:20 AM until the meal was removed at 12:06 PM did staff assist the resident or encourage meal consumption. The meal remained untouched.	F 312	F312 Cont. from page 9 Methodology: Direct observation, Nurse Managers will do random audits of room tray delivery and feeding assistance to reported weekly to DON Numerator: # of residents receiving meal assistance as directed by care plan Denominator: # of residents that require meal assistance per care plan Evaluation: Nurse Managers will report audit results weekly to DON and monthly at the Quality committee by DON or designee	
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 10 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to monitor, assess, and implement preventive treatment and care for 1 of 3 sample residents (#114) with pressure sores. This resulted in harm to the resident as evidenced by the development of avoidable pressure sores. The findings were 1. Review of the 8/13/09 significant change Minimum Data Set showed the facility assessed resident #114 as at risk for pressure sores, occasionally incontinent of bowel and frequently incontinent of bladder, and as requiring extensive assistance for transfers and bed mobility. Review of the 8/23/09 care plan confirmed staff needed to assist the resident with bed mobility and incontinence care, and on 8/09 staff were instructed to use a full sling lift for transfers. Further review of the care plan showed staff were to initiate the skin care protocol and "treat ulcer on hip as ordered." In addition, it was noted on 9/16/09 that the resident had a pressure ulcer on the right ankle and was placed on an air mattress. Observation on 9/25/09 at 10:08 AM revealed the resident also had two open areas between the buttocks, and the area around the anus was excoriated. The following concerns related to the new pressure sores between the resident's	F 314	F314 – Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This will be accomplished by: A.) Resident #114 - Resident was assessed by wound nurse on 9/26/09 expired on 9/28/09. B.) Weekly at risk meeting, update care plans, interdisciplinary involvement, scripting, re-approaching regarding positioning, and family involvement. All residents have the potential to be affected. System improvements related to wound and skin will be implemented for all residents effective 11-11-09. C.) Bath form revision to include skin condition communication between direct care providers by 11-11-09 Development of skin assessment documentation form. This assessment will include use of the Braden scale and implementation of interventions will be based on the scale. Form developed and	11/11/09

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F 314	Continued From page 11 buttocks were identified: a. No information related to the pressure sores between the buttocks was included in the care plan. b. Both open areas were covered with yellow slough tissue. The area closest to the anus was approximately 1.5 centimeter (cm) long by 0.7 cm wide. The second open area was approximately 2 cm by 0.5 cm. c. The area under the tape holding the old dressing was scabbed and had fresh bleeding where the scab was pulled off when tape was removed. Although RN #5 provided care as ordered, she replaced the dressing in the same place, applying paper tape directly on the scabbed and bleeding area. d. Review of the nursing notes showed the first documentation of an open area was dated 9/13/09. This was described as "2 cm crack above anus - bleeding. Covered with telfa and medipore tape." A precise description and definitive measurements were not documented. e. On 9/15/09 documentation showed the "crack" above the anus was larger with a "2nd area also open." Again, definitive measurements and a description were lacking. f. Although the physician was notified of the initial wound on 9/13/09 and treatment orders obtained, there was no evidence the physician was notified the wound was not improving or that a second one had developed. Physical therapy (PT) was not involved with the resident's care until 9/18/09. On that date the therapist saw the resident once and recommended an air mattress, an every two hour turning schedule, and medipore tape. The therapist documented that debridement or skilled PT was not required. g. Although documentation on 9/20/09 showed the facility's assessment was an	F 314	F314 cont. from page 11 implemented by 11-01-09 Care plan will be updated by nurse caring for resident, wound nurse will update after weekly rounds A weekly "at risk" meeting will be held to discuss any new admissions, residents with weight gain or loss, change in behavior and skin issues. Meeting will be attended by wound care nurse, DON, nurse managers, dietary and a representative from therapies (PT, OT, and speech, restorative). Care plans will be updated based on issues identified. Implemented by 11-11-09 Nutritional supplements will be documented on MAR. Implemented by 11-01-09 Development of a binder to include policies, forms and treatment protocol will be placed at all nurses' stations. Implemented by 11-11-09 Skills stations with competency check list for all direct care staff will be completed by 10/30/09. Skills station to include documentation, assessment, communication, repositioning, scripting regarding re-approaching resident and resident education. Certified wound care nurses' schedule increased to 24 hours per week	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535022	A. BUILDING _____ B. WING _____	C 09/28/2009

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F 314	Continued From page 11 buttocks were identified: a. No information related to the pressure sores between the buttocks was included in the care plan. b. Both open areas were covered with yellow slough tissue. The area closest to the anus was approximately 1.5 centimeter (cm) long by 0.7 cm wide. The second open area was approximately 2 cm by 0.5 cm. c. The area under the tape holding the old dressing was scabbed and had fresh bleeding where the scab was pulled off when tape was removed. Although RN #5 provided care as ordered, she replaced the dressing in the same place, applying paper tape directly on the scabbed and bleeding area. d. Review of the nursing notes showed the first documentation of an open area was dated 9/13/09. This was described as "2 cm crack above anus - bleeding. Covered with telfa and medipore tape." A precise description and definitive measurements were not documented. e. On 9/15/09 documentation showed the "crack" above the anus was larger with a "2nd area also open." Again, definitive measurements and a description were lacking. f. Although the physician was notified of the initial wound on 9/13/09 and treatment orders obtained, there was no evidence the physician was notified the wound was not improving or that a second one had developed. Physical therapy (PT) was not involved with the resident's care until 9/18/09. On that date the therapist saw the resident once and recommended an air mattress, an every two hour turning schedule, and medipore tape. The therapist documented that debridement or skilled PT was not required. g. Although documentation on 9/20/09 showed the facility's assessment was an	F 314	F314 Cont. from page 12 D.) Outcome measure: 100% of residents will have a weekly skin assessment including Braden Scale. Methodology: Medical record review Numerator # of weekly skin assessments completed Denominator: # of residents reviewed. Evaluation: Nurse Managers will report weekly to DON on completion of skin assessment and monthly at the Quality committee by DON or designee E.) Outcome measure: 100% of residents will receive skin care as directed by the care plan. Numerator: # of residents with skin care as directed by the care plan. Denominator: # of residents reviewed. Evaluation: Nurse Managers will report audit results weekly to DON and monthly at the Quality committee by DON or designee	

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F 314	Continued From page 12 "increased area of breakdown," the treatment was not evaluated for effectiveness and/or needed changes. h. During the observation on 9/25/09, RN #5 stated the resident would not allow repositioning off his/her back. After completion of the wound treatment, the RN did ask the resident if s/he would allow staff to reposition him/her. The resident refused, but none of the staff tried to encourage the resident to change positions or explained the necessity and benefits of moving off his/her back. The resident remained in the same position from 10:20 AM until lunch; staff made no attempt to reposition him/her during this time. On 9/25/09 at 4:40 PM the nurse manager stated she thought the original wound opened on 9/12/09, but confirmed documentation to that effect was lacking. The manager also stated the wound nurse had not seen the resident and obtained measurements as she "ran out of time...." On 9/28/09 at 1:40 PM, the manager stated per a telephone conversation that no other information prior to 9/25/09 was available.	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F315 – Bases on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #110	11/11/09

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F 315	Continued From page 13 Based on observation and medical record review, the facility failed to provide appropriate treatment and services to promote dryness for 1 of 4 sample residents (#110) with urinary incontinence. In addition, staff failed to appropriately manipulate the indwelling urinary catheter for 1 non-sample resident (#112). The findings were: 1. Review of the 9/18/09 care plan showed resident #110 was to be toileted "in AM, before and after meals..." as s/he was frequently incontinent of bowel and bladder. Review of the 9/8/09 notes from the interdisciplinary care plan conference revealed staff were to ask and toilet the resident even if family were present. On 9/25/09 observation showed the resident was eating breakfast at 7:50 AM. Further observation showed the resident remained seated in a wheelchair from 7:50 AM to 12:25 PM, when staff assisted the resident to the toilet at the request of the surveyor. At that time the resident was noted to have been incontinent of urine, and the skin on his/her buttocks was pink. 2. Observation on 9/25/09 at 9:45 AM showed non-sample resident #112 had an indwelling urinary catheter. During this observation, certified nursing assistants (CNAs) #6 and #9 provided perineal care and turned the resident and RN #5 entered the room to administer medications. While providing care, both RN #5 and CNA #6 lifted the resident's catheter drainage bag approximately 18 inches above the resident, and urine drained back into the resident's bladder.	F 315	F315 Cont. from page 13 A.)Nursing manager currently checking to ensure compliance with care plan interventions daily. Policies, processes, and orientation are in place for direct care staff related to incontinence care. Disciplinary actions with education were completed with the 2 involved staff members. Leadership team will audit performance of all employees during day to day routine and intervene immediately with corrective action. Resident #112 Policies, processes, and orientation are in place for direct care staff relating to catheter care. Disciplinary actions with education were completed with the 2 involved staff members. Leadership team will audit performance of all employees during day to day routine and intervene immediately with corrective action. B.) All residents have the potential to be affected.	
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards	~~F 323~~		

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F 315	Continued From page 13 Based on observation and medical record review, the facility failed to provide appropriate treatment and services to promote dryness for 1 of 4 sample residents (#110) with urinary incontinence. In addition, staff failed to appropriately manipulate the indwelling urinary catheter for 1 non-sample resident (#112). The findings were: 1. Review of the 9/18/09 care plan showed resident #110 was to be toileted "in AM, before and after meals..." as s/he was frequently incontinent of bowel and bladder. Review of the 9/8/09 notes from the interdisciplinary care plan conference revealed staff were to ask and toilet the resident even if family were present. On 9/25/09 observation showed the resident was eating breakfast at 7:50 AM. Further observation showed the resident remained seated in a wheelchair from 7:50 AM to 12:25 PM, when staff assisted the resident to the toilet at the request of the surveyor. At that time the resident was noted to have been incontinent of urine, and the skin on his/her buttocks was pink. 2. Observation on 9/25/09 at 9:45 AM showed non-sample resident #112 had an indwelling urinary catheter. During this observation, certified nursing assistants (CNAs) #6 and #9 provided perineal care and turned the resident and RN #5 entered the room to administer medications. While providing care, both RN #5 and CNA #6 lifted the resident's catheter drainage bag approximately 18 inches above the resident, and urine drained back into the resident's bladder.	F 315	F315 Cont. from page 14 All Pioneer Manor Residents have an interdisciplinary plan of care. Implementation of the plan of care by competent staff is an expectation at Pioneer Manor. Nursing leadership will do random observations during day to day routine and intervene immediately with corrective actions. C.) Skills stations with competency check list for all direct care staff will be completed by 10/30/09. Skill station topics will be incorporated into new employee education and orientation (privacy, incontinence care). Hands on competency evaluations to be completed by Nurse Managers (20 per month) and/or if indicated by QI infection control trends, etc. Education with competency checks will be completed by 10-30-09. Annual education and orientation of new employees by 12-01-09	
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards	~~F 323~~	D.) Outcome Measure: 100% of direct care staff will demonstrate competency in urinary catheter care. Methodology: Direct observation	

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F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 14 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interviews, the facility failed to ensure warning devices were applied to prevent elopement for 1 of 5 sample residents (#118) who was assessed as being at risk for falls. This resulted in avoidable harm for the resident who eloped and sustained a fall with injury. The findings were: Review of the undated "Elopement Risk Assessment" showed resident #118 had previously left the facility without needed supervision on 11/4/08, 2/7/09, 2/13/09, 5/1/09, and 5/14/09. In addition, the nursing notes documented the resident tried to leave the facility on 5/6/09 by the physical therapy door and by the elevator on 5/9/09. Review of the 5/19/09 interdisciplinary care plan conference notes showed safety devices included a floor alarm; there was no evidence of a discussion to place an alarm on the resident or on the wheelchair. However, according to the care plan, an alarm bracelet was added on 5/20/09. The following concerns with lack of safety devices were noted: a. Review of the nursing notes showed no evidence the alarm was ever applied. On 9/28/09 at 2:05 PM the DON verified there was no evidence the alarm was applied. b. During an interview on 9/24/09 at 9:20 PM, a family member stated someone from the family	F 323	F323 – The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: Resident #118 expired on 09/06/09 A.) All residents have the potential to be affected. System improvements as outlined below will be implemented for all residents effective 11-11-09. B.) Care planning - All Pioneer Manor Residents have an interdisciplinary plan of care. Implementation of the plan of care by competent staff is an expectation at Pioneer Manor Incident reporting – Development of incident binder to include policies, forms and check lists to be placed at all nurses' stations. Reviewed information at monthly Nurses' meeting held on 10-19-09. Form to be implemented by 11-01-09. Development of "Alert Charting" policy and form to be implemented on 11-11-09. Elopement Risk – Development of elopement risk binder to include pictures of high risk elopement residents to be placed at all nurses' stations and other sites as	11/11/09

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F 323	Continued From page 14 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interviews, the facility failed to ensure warning devices were applied to prevent elopement for 1 of 5 sample residents (#118) who was assessed as being at risk for falls. This resulted in avoidable harm for the resident who eloped and sustained a fall with injury. The findings were: Review of the undated "Elopement Risk Assessment" showed resident #118 had previously left the facility without needed supervision on 11/4/08, 2/7/09, 2/13/09, 5/1/09, and 5/14/09. In addition, the nursing notes documented the resident tried to leave the facility on 5/6/09 by the physical therapy door and by the elevator on 5/9/09. Review of the 5/19/09 interdisciplinary care plan conference notes showed safety devices included a floor alarm; there was no evidence of a discussion to place an alarm on the resident or on the wheelchair. However, according to the care plan, an alarm bracelet was added on 5/20/09. The following concerns with lack of safety devices were noted: a. Review of the nursing notes showed no evidence the alarm was ever applied. On 9/28/09 at 2:05 PM the DON verified there was no evidence the alarm was applied. b. During an interview on 9/24/09 at 9:20 PM, a family member stated someone from the family	F 323	F323 Cont. from page 15 appropriate. Elopement procedure binder to include policies, forms, and checklist to be placed at all nurses' stations. Evaluation of all residents for elopement risk and revision of care plan as indicated. Re-evaluation of residents per facility policy. Pressure ulcers -Revision of skin and wound assessment policy and protocols by 11-11-09. Bath form revision to include skin condition communication between direct care providers by 11-11-09. Development of skin assessment documentation form. This assessment will include use of the Braden scale and implementation of interventions will be based on the scale. Form developed and implemented by 11-01-09 Care plan will be updated by nurse caring for resident, wound nurse will update after weekly rounds A weekly "at risk" meeting will be held to discuss any new admissions, residents with weight gain or loss, change in behavior and skin issues. Meeting will be attended by wound care nurse, DON, nurse managers, dietary and a representative from therapies (PT, OT, and speech, restorative). Care plans will be updated based on issues identified. Implemented by 11-11-09.Nutritional supplements will be documented on MAR. Implemented by 11-01-09. Development of a binder to include policies, forms and treatment protocol will	

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F 323	Continued From page 14 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interviews, the facility failed to ensure warning devices were applied to prevent elopement for 1 of 5 sample residents (#118) who was assessed as being at risk for falls. This resulted in avoidable harm for the resident who eloped and sustained a fall with injury. The findings were: Review of the undated "Elopement Risk Assessment" showed resident #118 had previously left the facility without needed supervision on 11/4/08, 2/7/09, 2/13/09, 5/1/09, and 5/14/09. In addition, the nursing notes documented the resident tried to leave the facility on 5/6/09 by the physical therapy door and by the elevator on 5/9/09. Review of the 5/19/09 interdisciplinary care plan conference notes showed safety devices included a floor alarm; there was no evidence of a discussion to place an alarm on the resident or on the wheelchair. However, according to the care plan, an alarm bracelet was added on 5/20/09. The following concerns with lack of safety devices were noted: a. Review of the nursing notes showed no evidence the alarm was ever applied. On 9/28/09 at 2:05 PM the DON verified there was no evidence the alarm was applied. b. During an interview on 9/24/09 at 9:20 PM, a family member stated someone from the family	F 323	F323 Cont. from page 15 be placed at all nurses' stations. Implemented by 11-11-09. Skills stations with competency check list for all direct care staff will be completed by 10/30/09. Skills station to include documentation, assessment, communication, repositioning, scripting regarding re-approaching resident and resident education. Certified wound care nurses' schedule increased to 24 hours per week. Documentation - A new procedure for processing physician orders is being evaluated and will be implemented by 11-11-09. All physician orders will be sent directly to the nurse caring for the resident. The nurse will be responsible to clarify any unclear orders and document the clarification. The order will then be placed in the chart, the care plan will be updated, the resident and family will be notified of the new orders and the orders will be implemented. Night nurse will complete a 24 hour check of all charts to confirm all new orders have been implemented. The nurse will document in the chart that the 24 hour check was completed. Interventions as directed by the care plan will be documented. Utilization of Alarms devices – Provided wander guard training to professional nurses on 10-20-09. All staff education to notify	

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F 323	Continued From page 14 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interviews, the facility failed to ensure warning devices were applied to prevent elopement for 1 of 5 sample residents (#118) who was assessed as being at risk for falls. This resulted in avoidable harm for the resident who eloped and sustained a fall with injury. The findings were: Review of the undated "Elopement Risk Assessment" showed resident #118 had previously left the facility without needed supervision on 11/4/08, 2/7/09, 2/13/09, 5/1/09, and 5/14/09. In addition, the nursing notes documented the resident tried to leave the facility on 5/6/09 by the physical therapy door and by the elevator on 5/9/09. Review of the 5/19/09 interdisciplinary care plan conference notes showed safety devices included a floor alarm; there was no evidence of a discussion to place an alarm on the resident or on the wheelchair. However, according to the care plan, an alarm bracelet was added on 5/20/09. The following concerns with lack of safety devices were noted: a. Review of the nursing notes showed no evidence the alarm was ever applied. On 9/28/09 at 2:05 PM the DON verified there was no evidence the alarm was applied. b. During an interview on 9/24/09 at 9:20 PM, a family member stated someone from the family	F 323	F323 Cont. from page 15 nursing of elopement attempts by 10-30-09. C.) Outcome Measures: 100% of the residents will be evaluated for elopement risk. Methodology: Medical Record review Numerator: # of residents documented elopement risk Denominator: # of residents Evaluation: Skill stations with competency checks will be completed 10/30/09. Skill station topics will be incorporated into new employee education and orientation by 12/01/09. Nurse Managers will report audit results weekly to DON and monthly at the Quality committee by DON or designee D.) Outcome Measures: 100% of incident reports completed accurately (incident, notification, follow-up intervention, documentation) Methodology: Incident report review Numerator: # of incident reports completed accurately Denominator: # of incident reports Evaluations: Skill stations with competency checks will be completed 10/30/09.	

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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 323	Continued From page 15 visited the resident daily, and an alarm was never placed on the resident or on the wheelchair. c. Further review of nursing notes dated 6/21/09 revealed the resident was found outside the facility "on ground, fall unwitnessed. Was in [his/her] W/C (wheelchair) appeared [s/he] tumbled out on ground from W/C." Documentation from 6/21/09 through 6/26/09 showed the resident sustained a large hematoma which worsened and ultimately resulted in the resident's decline to non-weight bearing status. d. The aforementioned interview with the family member revealed the resident never regained his/her previous status. The family member confirmed the resident was non-weight bearing and s/he stated the resident developed a pressure sore. Review of the physician's orders confirmed, that by 9/2/09, the resident did have a pressure ulcer. The facility's failure to evaluate the resident's elopement attempts and implement appropriate interventions resulted in an avoidable fall, injury, and decline for the resident.	F 323	F323 Cont. from page 15 Monday – Friday review of incident reports at stand-up meetings. Action items distributed as appropriate. Nurse Managers will report audit results weekly to DON and monthly at the Quality committee by DON or designee	
F 353 SS=E	483.30(e) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353	F353 – The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. This will be accomplished by: A.) Resident #4 - Nurse Managers reviewed September bath summary, confirmed that there was no documentation of baths given from	11/1/09

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F 353	Continued From page 16 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident, family, and staff interviews, and review of grievance information and the nursing staff schedule, the facility failed to maintain sufficient nursing staff to provide needed services for residents. Specific residents involved included #4, #16, #22, #65, #71, #110, #112 #114, and #119. The findings were: Refer to F312 for details related to lack of assistance with bathing and meal assistance. Refer to F315 for information regarding failure to promote urinary continence. Observation on 9/23/09 at 6:45 PM revealed there were three certified nursing assistants (CNAs) for Neighborhoods (N) 3 and 4 and three for N5A and B. Review of the census provided by the facility showed 21 residents resided on N3 and 19 on N4 for a total of 40 residents to be cared for by three CNAs. These two neighborhoods were in different halls. N5A housed 20 residents and 19 residents lived on N5B, for a total of 39 residents to receive care from 3 CNAs. This neighborhood was a single, angled hall with the nursing station located close to the middle. Staff could not see from 5A around	F 353	F353 Cont. from page 16 September 4-13th and 15th-20th. Resident received 5 baths from September 21st-28th. See organization correction plan below Resident #22 - Nurse Manager reviewed bath schedule, no documentation of bathing noted for 23 days Interviewed staff, reported resident had refused, oral counseling with education provided regarding resident rights and documentation. See organization correction plan below. Resident #65 - There is a discrepancy on the 2567 form, there is no # 65 listed on the sample list of residents. See organization correction plan below. Resident #71 - Nurse Managers confirmed that there was no documentation of any baths given from 9-09-09 to 9-15-09, resident received scheduled baths rest of the month. See organization correction plan below. Resident #114 - Resident expired on 9/28/09 Resident #16 - Nurse Manager reviewed September bath summary sheets, confirmed that there was no documentation of baths given from September 9th-15th. On 9-28-09 Nurse manager reviewed bath summary form with resident regarding week of September 19th-documentation noted that	

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F 353	Continued From page 17 the angle in the hall to the end of 5B. Nor could they hear from one end of the hall to the other. During confidential interviews two residents and three different family members stated the facility was frequently short of staff. They cited lack of baths, failure to answer call lights, and lack of assistance into, or out of, the bathroom as particular issues. Confidential interviews between 9/23/09 and 9/25/09 with three licensed practical nurses (LPNs) and two CNAs revealed they did not have enough help. Two of the LPNs stated the residents on N5 were heavy care and many required 2 CNAs to complete care. They stated the CNAs started at N5A and assisted residents consecutively until they reached the end of N5B. They further stated that might be three hours later. The CNAs stated baths were frequently missed and they were five to six days behind. They stated baths could be given or other residents cared for; either way, the dependent residents suffered as most could not or would not complain. Review of the nursing schedule showed there were frequently only 3 CNAs scheduled to work on N5A and B, particularly in the evening during the last week of August and in September 2009. Interview with the administrator and director of nursing (DON) on 9/23/09 at 7:15 PM revealed they were aware of the concern and that changes were needed. They stated they had a plan to covert certified ancillary staff to direct care, but confirmed it had not yet been instituted.	F 353	F353 Cont. from page 17 Resident #16 had received baths on 9-22-09 & 9-24-09. In August, resident's bath schedule changed from days to evening shift per his request. See organization correction plan below Resident #91 - Nurse manager reviewed bath schedule, confirmed that resident did not receive baths as scheduled. Counseling with education provided to CNA's. See organization correction plan below Resident #119 discharged to home on 6-19-09 B.) All residents have the potential to be affected, Leadership team monitoring staffing, resident acuity daily and intervening immediately per availability. Nursing department keeping call-log of attempts to fill schedule openings C.) Time studies completed with Restorative aides, transportation aides, sunshiners, ward clerk, and nursing secretary. Opportunities were identified to use these staff in direct resident care and implemented 10-19-09. 80 hours of restorative aide schedule has been reassigned for direct care weekly. Certified ancillary staff will be oriented and reassigned to direct care as appropriate.	

DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2009
FORM APPROVED
OMB NO. 0938-0391

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