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

PRINTED: 05/20/2010
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 _____ | 05/06/2010 |

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

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| F 000 | INITIAL COMMENTS<br><br>The following abbreviations are provided here for reference and will be used throughout the remainder of the 2567 document:<br><br>CNA- Certified nurse aide<br>DON- Director of nursing<br>LPN- Licensed practical nurse<br>MAR- Medication administration record<br>RN- Registered nurse | F 000 | | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interview, and medical record review, the facility failed to ensure one non-sample resident (#64) received services to assist in obtaining funding or other assistance in order to get a necessary vision examination. The findings were:<br><br>Interview with non-sample resident #64 on 5/4/10 at 1 PM revealed s/he was still waiting for a vision appointment that was requested almost a year ago. Review of a 5/5/09 referral request to social services confirmed the resident's statement, the request showed the resident was having "vision difficulties- needs to see eye doctor." The following concerns were noted:<br>a. Review of the referral response showed it was dated 7/9/09 (two months after the request) | F 250 | F250<br>Pioneer Manor will ensure that all requests for vision, dental and hearing appointments will be referred to Social Services to maintain the highest practicable physical, mental and psychosocial well-being of each resident. This will be accomplished by:<br><br>• Resident # 64 has a vision appointment scheduled for Friday, May 28, 2010.<br><br>• All requests for vision, dental, and hearing appointment will be referred to Social Services to verify provider and evaluate funds available.<br><br>• Social Services referral form will be used by all staff to request ancillary medical services as listed up above. | 6/20/10 |

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

E.A. Goodall, LNHA — Administrator — 6/3/10

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.

Accepted via mail dpt for NHA - date of completion all tags = 6/20/10.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E40111 Facility ID: WY0021 If continuation sheet Page 1 of 21

JUN 03 2010
Wyoming Dept of Health
Office of Healthcare Licensing and Surveys

6/18/10

6/8/10

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| F 250 | Continued From page 1<br>and the appointment could not be scheduled at that time due to "No funds available." Further review showed no evidence funds were being sought related to the needed appointment.<br>b. Interview with the director of nursing on 5/6/10 at 4 PM revealed the resident still had not been scheduled for the vision appointment. | F 250 | F250 Continued from page 1.<br>• All staff will be educated regarding the new process by June 20, 2010. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to ensure the care plan for 1 of 14 sample residents (#61) was updated. The findings were: | F 280 | | |

6/4/10

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| F 250 | Continued From page 1<br>and the appointment could not be scheduled at that time due to "No funds available." Further review showed no evidence funds were being sought related to the needed appointment.<br>b. Interview with the director of nursing on 5/6/10 at 4 PM revealed the resident still had not been scheduled for the vision appointment. | F 250 | F250 Continued from page 1.<br><br>Social Services will collect this information and report findings at the monthly QA meeting. Any deficiencies will be individually evaluated; Care Plan meetings to include review of need for ancillary medical services. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to ensure the care plan for 1 of 14 sample residents (#61) was updated. The findings were: | F 280 | F280<br>Pioneer Manor will ensure that resident #61 and all other residents and or their families, unless demeaned incompetent or otherwise found to be incapacitated under the laws of the State, will participate in planning of care/treatment or changes in care/treatment. Additionally, comprehensive care plans for each resident will be developed, prepared, reviewed and updated by appropriate staff, physicians and nurses. This will be accomplished by:<br><br>Resident #61:<br>• Care plan based on appropriate assessment to reflect wheelchair bound with seatbelt status and feeding assistance completed May 26, 2010.<br><br>• Care Planning meeting to reflect assessments and triggers.<br><br>• Evaluate care planning process to determine barriers to completion by June 20, 2010<br><br>• Staff specific to this process will be inserviced by June 20th. | 6/20/10 |

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| F 280 | Continued From page 2<br>Review of the 2/2/10 care plan for resident #61 showed s/he was independent in bed mobility and transfers, ambulated with a walker or cane, and was able to feed him/herself. Observation on 5/6/10 from 8:15 AM until 11:30 AM showed the resident was wheelchair bound with a seatbelt and required total feeding assistance by staff. Interview with the DON on 5/6/10 at 1:30 PM verified that the care plan was inaccurate and did not reflect the current status of the resident. She stated the care plan should be updated. | F 280 | F280 Continued from page 2.<br><br>Nurse Managers or delegate to audit 10 charts per week for assessments and care planning to reflect assessments utilizing audit tool and MDS triggers. Findings will be reported monthly to the QA meeting, with discrepancies investigated and resolved. | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and medical record review, the facility failed to ensure diet orders were accurate and based on resident needs for 1 of 13 sample residents (#34) who had therapeutic diets. The facility failed to ensure nursing assessment, monitoring, and measures were in place to prevent falls for 6 of 14 sample residents (#15, #34, #35, #40, #76, #118) and 2 non-sample residents (#120, #121). The facility failed to ensure a safe environment was maintained for 1 of 4 sample residents (#67) who lived in the secure unit. Finally, staff failed to perform a side rail safety assessment for 8 of 10 sample residents who had side rails (#14, #15, | F 323 | F323<br>Pioneer Manor will ensure that the resident environment remains free of accident hazards and that each resident receives adequate supervision / assistance devices to prevent accidents. This will be accomplished by:<br><br>**Diet orders accurate**<br>• Resident # 34:<br><br>• On May 5, 2010 Registered Dietician requested an order for a Regular diet with pureed textures with nectar thick liquids. Speech evaluation completed on May 10, 2010. Doctors' order received for a regular diet with pureed textures noted May 11, 2010. Diet order has been added to care plan and dietary records including tray cards have been updated. | 6/20/10 |

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| F 323 | Continued From page 3<br>#31, #34, #48, #49, #73, #118). The findings were:<br><br>1. Refer to Federal citation F 365 for details regarding the failure to assess safe swallowing capability for resident #34, whose food texture needs had apparently changed.<br><br>2. Review of the medical record for resident #67 showed s/he had diagnoses including depressive disorder and Huntington's Chorea. Review of the nursing notes showed the resident singed his/her hair with a lighter on 1/22/10 and stated s/he wanted to kill him/herself. The record also showed the resident said s/he wanted to kill him/herself on 1/24/10. Review of the nursing notes revealed on 4/5/10 at 8:15 PM the resident removed shoestrings from a pair of shoes and said s/he wanted to kill him/herself. Observation of the secure unit on 5/6/10 from 8 AM to 11:30 AM showed there was a blood pressure cuff with a cord, a stethoscope, a cart with hanging cords, and a telephone with an expandable cord unsecured in the living/dining area. Periodic observations showed the resident was in and out of the area where the potentially hazardous items were located. Interviews with the administrator on 5/6/10 at 9:15 AM and with the DON at 1:30 PM, revealed the aforementioned items posed a safety risk and should to be secured.<br><br>Safety of side rails<br><br>1. Observation on 5/4/10 from 8:30 AM to 11:30 AM revealed resident #73 had two half side rails on his/her bed. Review of the 4/17/09 and 1/6/10 side rail assessments documented the resident had fluctuations in level of consciousness and had cognitive deficits. These assessments also | F 323 | F323 Continued from page 3.<br><br>**Falls prevention**<br>• #15, #34, #35, #40, #76, # 118 #120, #121, #60<br><br>o # 34 fall assessment reviewed and interventions implemented on care plan. Nurse Managers/MDS Coordinators to verify interventions in place. All alarms verified in working order. Care plan to reflect interventions to include bed operation.<br><br>o #60, #120, #121 Nursing and Housekeeping education per managers related to mopping floor and residents walking on wet floor. Immediate change in process for leaving dry area as well as redirecting residents when mopping is occurring by both nursing and housekeeping completed May 7, 2010. Policy and procedure revision completed May 20, 2010. | |

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| F 323 | Continued From page 4<br>showed no evidence the side rails were assessed for potential entrapment of body parts, such as limbs, head, neck, or chest.<br><br>2. Observation on 5/4/10 from 9:27 AM to 11 AM showed resident #14 had two half side rails on the bed in the upright position while sleeping. Review of the 4/17/09 side rail assessment revealed no evidence an assessment was done to ensure the side rails could not entrap the resident.<br><br>3. Observation on 5/4/10 from 8:30 AM to 11:30 AM showed resident #48 had two half side rails in the upright position on his/her bed. Review of the 9/9/09 and 11/10/09 side rail assessments revealed the resident had periods of increased confusion. Further review revealed the assessment did not include a risk analysis of the side rails for entrapment.<br><br>4. Observation on 5/4/10 from 8:30 AM to 11:30 AM showed there were two half side rails on the bed for resident #31. Review of the side rail assessment completed on 4/22/10 showed the resident was confused at times. Review also showed no evidence the side rails were assessed to ensure entrapment could not occur.<br><br>5. Observations on 5/4/10 from 8:30 AM to 11:30 AM revealed there were two half side rails on the bed of resident #49. Review of the 7/10/09 and 9/23/09 side rail assessments showed the resident had increased periods of confusion. Further review of the side rail assessments showed it did not include a risk analysis of the rails for entrapment.<br><br>6. The following residents were observed | F 323 | F323 Continued from page 3.<br><br>o #76 complete fall assessment and care plan updated as appropriate, completed May 26, 2010.<br><br>**Safe environment**<br>• #67<br><br>o Office temporarily moved to secure area. May 7, 2010<br><br>o Successful medication change resident per Psychiatrist completed April 15, 2010. Resident was discharged from Hospice due to improvement on May 7, 2010. Care Pan updated to reflect condition improvement on May 26, 2010. Resident has a behavior tracking sheet that is monitored continually.<br><br>**Side rail assessment**<br><br>• # 14, #15, #31, #34, #48, #49, #73, #118 | |

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| F 323 | Continued From page 5<br>periodically throughout the survey (5/3-5/6/10) to use side rails while in bed. Review of the side rail assessments for these residents showed they consisted of yes and no questions that failed to adequately conclude if the side rails were safe:<br>a. Resident #15 used two half side rails. Review of the 4/17/09 assessment was incomplete as it did not include how the rails were measured or assessed for possible entrapment risks.<br>b. Resident #118 used two full side rails. Review of the 7/30/09 assessment failed to include evidence of how the rails were assessed or measured for entrapment risks.<br>c. Resident #34 used two half side rails. The 4/16/09 assessment failed to include entrapment risks.<br><br>Interview with the DON on 5/6/10 at 3 PM verified there were no other assessment documents to review.<br><br>Safety related to falls<br><br>1. Review of the 2/12/10 fall risk assessment for resident #34 showed s/he was at risk for falls. Review of the accident report showed the resident's last fall was unobserved on 2/12/10 and happened when the resident attempted to transfer from the wheelchair to the bed without assistance. According to the 3/31/10 care plan, the interventions listed for falls included a bed alarm, and a fall pad by the bedside. The following concerns were identified:<br>a. Observation on 5/4/10 at 8 AM showed the resident was attempting to get out of bed. There was no fall pad on the floor, and no alarm was sounding. The resident moved slowly and sat for 30 minutes with his/her legs draped over the edge | F 323 | F323 Continued from page 3.<br><br>o All above residents to have side rail assessments completed by RN by June 20, 2010 and results of assessment and interventions to be incorporated into care plan. Care Planning meeting to reflect use of side rails and evaluation to be completed to determine continued usage.<br><br>• **Diet orders accurate**<br><br>o Chart audits for correct diets have been completed on all residents and are consistent with physician order , verification of current diet requirements on care plan.<br><br>• **Falls prevention:**<br><br>o Fall assessments will be evaluated for accuracy and interventions implemented on care plan. | |

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| F 323 | Continued From page 6<br>of the bed. At 8:30 AM, two CNAs assisted the resident with getting up.<br>b. Observation on 5/4/10 at 5:10 PM revealed the resident was in bed watching television. The bed was in a raised position, and there was no fall pad on the floor. Interview and observation with the DON at that time revealed the bed should be in the low position, and the fall interventions should be in place. Upon inspection she confirmed there was no fall alarm on the bed. She further stated since the bed could be raised and lowered, it should be addressed in the care plan.<br><br>2. Observation on 5/6/10 at 7:55 AM in the secure unit showed housekeeper #1 had completed mopping the main dining area floor. The entire area was mopped and the floor was wet without any dry area to walk on. The housekeeper placed a cautionary sign in the area. At that time three residents (sample resident #60 and non-sample residents #120, #121) all walked on the wet floor to get coffee and/or sit at tables in the area. RN #1 was in the area, but did not attempt to redirect or caution the residents about the wet floor hazard. Interview with housekeeper #1 at 8:05 AM revealed she always mopped the entire floor after breakfast and without leaving any dry area. Interview with RN #1 revealed some residents were at risk for falls and walking on a wet floor could be a hazard. She stated the residents were usually directed to stay off the wet floor until it was dry. She stated she had not noticed the residents walking on the wet floor that morning. Medical record review showed each of these three residents who walked on the wet floor were at risk for falls based on fall assessments. Review of the care plans for each resident also identified monitoring for fall hazards in the environment was one of the interventions for preventing falls. | F 323 | F323 Continued from page 3.<br>• **Safety:**<br>o All staff to monitor environment for safety risks and report findings to leadership.<br>• **Side Rail assessment:**<br>o All residents will have side rail assessment completed by August 6, 2010, care plan updated as appropriate to assessment findings and quarterly Care Planning review and any significant change to include side rail assessment<br>• **Diet order correct:**<br>o Policy revision regarding diet modifications to be completed by June 20, 2010.<br>• **Fall prevention:**<br>o Nurse Managers/MDS Coordinators to verify interventions/assessments as directed by care plan in place. MDS Coordinator to do assessments prior to Care Planning meeting. | |

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| F 323 | Continued From page 6<br>of the bed. At 8:30 AM, two CNAs assisted the resident with getting up.<br>b. Observation on 5/4/10 at 5:10 PM revealed the resident was in bed watching television. The bed was in a raised position, and there was no fall pad on the floor. Interview and observation with the DON at that time revealed the bed should be in the low position, and the fall interventions should be in place. Upon inspection she confirmed there was no fall alarm on the bed. She further stated since the bed could be raised and lowered, it should be addressed in the care plan.<br><br>2. Observation on 5/6/10 at 7:55 AM in the secure unit showed housekeeper #1 had completed mopping the main dining area floor. The entire area was mopped and the floor was wet without any dry area to walk on. The housekeeper placed a cautionary sign in the area. At that time three residents (sample resident #60 and non-sample residents #120, #121) all walked on the wet floor to get coffee and/or sit at tables in the area. RN #1 was in the area, but did not attempt to redirect or caution the residents about the wet floor hazard. Interview with housekeeper #1 at 8:05 AM revealed she always mopped the entire floor after breakfast and without leaving any dry area. Interview with RN #1 revealed some residents were at risk for falls and walking on a wet floor could be a hazard. She stated the residents were usually directed to stay off the wet floor until it was dry. She stated she had not noticed the residents walking on the wet floor that morning. Medical record review showed each of these three residents who walked on the wet floor were at risk for falls based on fall assessments. Review of the care plans for each resident also identified monitoring for fall hazards in the environment was one of the interventions for preventing falls. | F 323 | F323 Continued from page 3.<br><br>o Review activity and restorative program to enhance fall prevention and safety, completed June 20, 2010.<br><br>o All Staff Education to be completed by June 20th, 2010.<br><br>• **Side Rail Assessment:**<br><br>o Side Rail assessments to be completed and findings/interventions on care plan<br><br>Rounds by Housekeeping manager or designee to determine compliance with mopping, cleaning procedures.<br><br>10 charts per week will be reviewed by leadership team for the following: assessment and findings/interventions on care plan (fall prevention, safety, side rails, and diet orders). Data will be presented monthly at the QA meeting. Discrepancies will be investigated and resolved. | |

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| | 535022 | A. BUILDING _____ B. WING _____ | 05/06/2010 |

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

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|---|---|---|---|---|
| F 323 | Continued From page 7<br><br>3. Review of the 10/7/09 admission Minimum Data Set assessment for resident #76 showed the resident needed extensive assistance of two staff members to transfer and was totally dependent for locomotion. The MDS assessment prompted a fall Resident Assessment Protocol (RAP), which referred to a fall risk assessment. Further record review showed staff failed to date the fall risk assessment, and the assessment was incomplete as the area for interventions was blank. Although the resident had not had any falls, review of the resident's care plan showed the facility had not added interventions to address the resident's risk for falls until 1/10/10. | F 323 | | |
| F 329 SS=E | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | F 329 | F329<br>Pioneer Manor will ensure that proper monitoring and distribution of drugs will be applied towards all residents to prevent distribution of unnecessary drugs. This will be accomplished by:<br><br>Resident #21:<br>▪ Completion of sleep evaluation using sleep evaluation form. Assessment findings to be placed on care plan and communicated to physician for medication review completed May 27, 2010.<br><br>▪ Pharmacy review of sleep evaluation to be completed as part of monthly review. Sleep evaluation to be a component of Care Planning meetings. | 6/20/10 |

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

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OMB NO. 0938-0391

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| F 329 | Continued From page 8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure drug regimens were free of unnecessary drugs for 5 of 14 sample residents (#21, #31, #34, #35, #66). The findings were:<br><br>1. Review of physician orders for resident #21 showed an order dated 5/28/09 for temazepam (a sedative-hypnotic) 15 mg nightly, and an order dated 4/2/09 for Cymbalta (an anti-depressant) 60 mg daily. The following concerns were identified with the use of these medications:<br>a. Review of the resident's March, April 2010, and May 2010 MARs showed the resident received the temazepam 15 mg each night and Cymbalta 60 mg each day.<br>b. Review of the medical record showed the facility failed to complete a comprehensive sleep assessment to determine the resident's usual sleep pattern/disturbance, and if non-pharmacological interventions would be useful.<br>c. Medical record review showed the facility failed to attempt a dose reduction for temazepam or Cymbalta or to obtain a statement from the physician that explained why each medication should be continued without change.<br><br>2. Review of the physician's orders for resident #31 showed an order dated 8/14/09 for lorazepam (an anti-anxiety medication). Review of the March, April and May 2010 MARs showed | F 329 | F329 Continued from page 8.<br><br>Resident #31:<br>• Consultant Pharmacist Medication Regimen Review and Physician Notification form completed May 5,, 2010.<br><br>• Behavior tracking log initiated on May 7, 2010.<br><br>• Assessment findings added to care plan completed May 27, 2010.<br><br>Resident #35:<br>• Completion of sleep evaluation using the sleep evaluation form. Assessment findings to be placed on care plan completed May 26, 2010.<br><br>• Pharmacy review of sleep evaluation to be completed as part of monthly review. Sleep evaluation to be a component of Care Planning meetings.<br><br>• Physician addressed sleeping medication on May 13, 2010.<br><br>Resident #34:<br>• Consultant Pharmacist Medication Regimen Review and Physician Notification form completed May 6, 2010. | |

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

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FORM APPROVED
OMB NO. 0938-0391

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| F 329 | Continued From page 9<br>the resident received the lorazepam almost daily since 8/14/09. Review of the drug regimen review revealed the physician indicated, in regard to the lorazepam, the resident was tolerating the psychotropic medication well, had no untoward side effects, and the benefits outweighed the risks. However, the record showed no evidence an attempted dose reduction was tried in the past that had caused the target symptoms to return or worsen. In addition, there was no evidence a gradual dose reduction attempt was clinically contraindicated due to a likelihood of impairing the resident's function or causing psychiatric instability by exacerbating an underlying medical or psychiatric disorder.<br><br>3. Review of the March, April and May 2010 MARs for resident #35 showed s/he received zolpidem tartrate 5 mg each night. The sleep medication was ordered on 3/11/09 for insomnia/sleeplessness to be used as needed. Review of the medical record failed to show any evaluation of the resident's insomnia, alternatives to the medication, and any attempt to evaluate the medications continued use. Interview with the DON on 5/6/10 at 3 PM confirmed the information failed to show rational for the continued use of the medication.<br><br>4. Review of the March 2010 recapitulation of physician orders showed resident #34 had orders for two antipsychotic medications, geodon 80 mg twice a day since 9/9/07 and Zyprexa zydis 20 mg at bedtime as ordered since 10/17/07. Review of the medical record failed to show any attempts at dose reductions or a statement by the physician to describe why a reduction would be contraindicated for these medications. Interview with the DON on 5/6/10 at 3 PM confirmed the | F 329 | F329 Continued from page 8.<br><br>• Behavior tracking log reviewed on May 26, 2010.<br><br>• Antipsychotic Medication Quarterly Evaluation/AIMS form to be completed May 26, 2010. Assessment findings added to care plan and reviewed at Care Planning meetings<br><br>Resident #66:<br>• Consultant Pharmacist Medication Regimen Review and Physician Notification form completed May 20, 2010.<br><br>• Behavior tracking log reviewed May 26, 2010. Care plan reviewed May 26, 2010. Physician review of medications and changes made on May 13, 2010.<br><br>• Completion of sleep evaluation using sleep evaluation form completed May 26, 2010. Assessment findings to be placed on care plan and communicated to physician for medication review completed May 26, 2010. Pharmacy review of sleep evaluation to be completed as part of monthly review. | |

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

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| F 329 | Continued From page 10<br>continued use of these medications needed to be evaluated.<br><br>5. Review of physician orders for resident #66 showed orders for doxepin (a tri-cyclic anti-depressant) 10 mg at bedtime on 7/17/09, and alprazolam (anti-anxiety) 0.5 mg every six hours as needed on 6/26/09. The following concerns were identified:<br>a. Review of the resident's MARs for April 2010 and May 2010 showed the resident received alprazolam 0.5 mg at least once each day, and Doxepin 10 mg daily.<br>b. Medical record review showed the facility failed to attempt a dose reduction for either medication or to obtain a statement from the physician that explained why each medication should be continued without change.<br><br>Interview with the DON on 5/6/10 at 1:30 PM revealed facility staff did not get together as a team to discuss medication regimens for residents. She further stated only the pharmacist reviewed the drug regimen reviews and worked with physicians to monitor medications. The DON said the facility was not doing what it should be to ensure the medications were appropriate and dose reductions occurred as needed, especially with psychotropic medications. | F 329 | F329 Continued from page 8.<br>Sleep evaluation to be a component of Care Planning meetings .<br><br>• All specific staff will complete necessary education by June 20th, 2010.<br><br>• All residents taking antipsychotics and/or sedatives/hypnotics will have an appropriate assessment to include pharmacy review, nursing assessment, and physician documentation of risk/benefits regarding medications. Findings/interventions will be reflected in the resident care plan.<br><br>Leadership team to audit 10 charts per month for the following (antipsychotic/AIMS assessment, sleep evaluation and documentation of risk vs benefits and report to monthly QA meeting. Discrepancies will be investigated and corrected. | |
| F 365 SS=D | 483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS<br><br>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>This REQUIREMENT is not met as evidenced by: | F 365 | F365<br>Pioneer Manor will ensure each resident receives prepared food provided by the facility in a form designed to meet each resident's individual needs. This will be accomplished by: | 6/20/10 |

6/18/10

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

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| F 365 | Continued From page 11<br>Based on observation, staff interview, and medical record review, the facility failed to ensure 1 of 13 sample residents (#34) with therapeutic diet orders was assessed to ensure s/he had a diet order that reflected the texture appropriate to the resident's current needs. Findings were:<br><br>Observation of resident #34 during the evening meal on 5/4/10 at 5:17 PM, and the lunch meal on 5/5/10 at 11:35 AM revealed the resident was served a diet with ground meat. The remainder of the diet was a regular consistency. During the meal observations it was noted the client ate without assistance and did not appear to have any difficulty with the texture of the foods. Review of the March 2010 physician's orders showed the resident had a diet order for a regular diet with pureed texture. According to the resident's care plan, dated 3/31/10, the resident was at risk of aspiration due to poor swallowing ability. One of the interventions on this plan was a pureed diet. Regarding the failure of the facility to re-evaluate this resident to ensure the diet order reflected the resident's highest level of function and abilities, the following concerns were noted:<br>a. Review of the 3/2/09 note written by the registered dietitian (RD) documented that the resident was on a mechanical ground diet. A 9/10/09 RD's not shows the resident was receiving a pureed diet secondary to dysphagia and the speech therapist's recommendation. Interview with the RD on 5/5/10 at 2:15 PM revealed the resident had orders for a pureed diet. The RD stated she was unable to find any recommendations to change the diet order.<br>b. Although the resident was capable of handling a mechanical soft diet per observation during the survey, and the resident's diet card showed s/he was receiving a mechanical soft, | F 365 | F365 Continued from page 11.<br><br>Resident 34:<br>• On May 5, 2010 Registered Dietician requested an order for a Regular diet with pureed textures with nectar thick liquids.<br><br>• Speech evaluation completed on May 10, 2010.<br><br>• Doctors' order received for a regular diet with pureed textures noted May 11, 2010. Diet order has been added to care plan and dietary records including tray cards have been updated.<br><br>• Chart audits for correct diets have been completed on all resident's May 11, 2010- May 13, 2010.<br><br>• All specific staff will be inserviced by June 20th, 2010.<br><br>Registered Dietician or delegate will audit 10 charts per week for diet order consistent with physician order and interventions/assessment will be reflected on resident's care plan. Data will be reviewed in the monthly QA meeting and any discrepancies will be individually addressed. | |

6/8/10

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 365 | Continued From page 12<br>ground meat diet, the facility had no evidence the resident had been reassessed to ensure s/he was swallowing safely or that the physician had been notified of the resident's improvement. | F 365 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure food was prepared in a sanitary manner in the main kitchen related to a lack of cleanliness of ceiling vents, and ceiling sprinklers. In addition, the facility failed to ensure food contact surfaces were effectively sanitized. Furthermore, the facility failed to establish a system to monitor foods that were stored in individual resident refrigerators to ensure foods were safely stored for 2 sample residents (#35, #73) and 16 non-sample residents (#1, #17, #23, #26, #41, #56, #58, #69, #82, #85, #96, #100, #101, #102, #115, #119). The findings were:<br><br>a. Observation on 5/5/10 at 8:50 AM revealed two cooks were working with food in the main preparation area of the kitchen. Two ceiling vents above this area were noted to be soiled with an accumulation of dust and grease. In addition, | F 371 | F371<br>Pioneer Manor will ensure each resident receives food that is prepared in a sanitary manner and environment. In addition, Pioneer Manor will ensure residents with individual refrigerators will be monitored to ensure foods are safely stored. This will be accomplished by:<br><br># 35, #73, #1, #17, #23, #26, #41, #56, #58, #69, #82, #85, #96, #100, #101, #102, #115, #119<br>• The temperature log for refrigerators has been updated to include all refrigerators within the resident's rooms and thermometers have been placed in all refrigerators temperatures will be taken weekly per policy.<br>• Ceiling grate replaced May 7, 2010 Sprinkler heads cleaned May 17, 2010 both of these items have been added to the cleaning schedule<br>• Sanitation log has been put in place to record the parts per million (PPM) that we take when filling the sanitation bucket | 6/20/10 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 371 | Continued From page 13<br>there were four sprinklers in the ceiling of this area that were also covered in thick dust and grease. Interview with the certified dietary manager (CDM) on 5/5/10 at 3:45 PM revealed new vents had been ordered, and she was not sure when they would be installed.<br>According to Food Code 2009, U.S. Public Health Service: 3-305.11 "(A)... Food shall be protected from contamination by storing food:(1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination..."<br><br>b. During observation of food preparation on 5/6/10 from 8:50 AM to 9:50 AM, cook #1 had completed preparing sandwiches for that day's alternative lunch meal. She was using a towel and bucket with a soapy solution to clean the preparation counter. She stated the solution was used to clean the area before and after the food preparation, and it contained bleach as the sanitizing agent. When asked if the solution had been tested for concentration of sanitizer, she stated it had not been tested. She also stated the concentration of the solution in this bucket was not recorded on any type of log when it was tested. The surveyor informed the cook that she would like to test the solution. Just as the surveyor was preparing to test the sanitizing solution, however, cook #1 purposely poured out the contents, thus effectively preventing the test. According to Food Code 2009, U.S. Public Health Service: 4-701.10 "Equipment food-contact surfaces and utensils shall be sanitized."<br><br>c. Random observation revealed some residents had personal refrigeration units in their rooms. The refrigerators of non-sample resident #1 and sample resident #35 were observed to contain | F 371 | F371 Continued from page 13.<br><br>• Staff education will be completed June 20th, 2010.<br><br>• 100% of cleaning solutions will be within range. Dietary supervisors and Manager will monitor cleaning assignments and refrigerator temp monitoring and report monthly results to QA committee. Discrepancies will be investigated and corrected. | |

6/8/10

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| F 371 | Continued From page 14<br>food such as yogurt and cookies. However, both units lacked a thermometer to ensure the interior temperature could be monitored. Resident #35 stated that as far as s/he knew, the temperature was not monitored. Interview with the CDM on 5/5/10 at 9:50 AM revealed the individual refrigerators should be checked each week when menus were distributed. Review of a list provided by the CDM on 5/5/10 of those residents in the facility that had their own refrigerators revealed residents #1 and #35 were not included. Further interview revealed there was no evidence of any monitoring. Review of a new comprehensive list provided by the CDM on 5/6/10 showed the following 18 residents had refrigerators in their rooms:#1, #17, #23, #26, #35, #41, #56, #58, #69, #73, #82, #85, #96, #100, #101, #102, #115, and #119). | F 371 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program | F 441 | F441<br>Pioneer Manor will ensure the facility establishes and maintains an Infection Control Program that is designed to provide a safe/sanitary and comfortable environment to assist and prevent the development/transmission of disease and infection. This will be accomplished by:<br><br>• RN #2, LPN #1, LPN #2, LPN #3<br><br>o All above nurses were given one on one instruction regarding cleansing of glucometer completed May 7, 2010. | 6/20/10 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 441 | Continued From page 15<br>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of the Centers for Disease Control recommendations, the facility failed to ensure staff followed appropriate infection control practices during 7 random observations. The findings were:<br><br>1. Observation on 5/4/10 at 4 PM showed RN # 2 used a glucometer to perform glucose tests on two non-sample residents (#84, #95). The observation also showed the RN did not clean the glucometer between resident uses. During an interview with the RN immediately after the observation, she stated glucometers were cleaned by the night shift every 24 hours.<br><br>2. Observation on 5/4/10 at 4:15 PM showed LPN #1 used a glucometer to perform glucose tests on | F 441 | F441 Continued from page 15.<br><br>o Additional Nurse Education provided for Professional Nurse's at nurses staff meeting on May 27, 2010. Immediate monitoring of cleaning process implemented.<br><br>• #84, #95, #37, #69, #23, #24, #70, #6, #77<br><br>o Glucometer cleaning between residents immediately implemented and monitored.<br><br>• #122, #6, #77, #1, #4<br><br>o Appropriate cleaning of glucometer per manufacturer recommendations implemented.<br><br>• Staff #1<br><br>o Immediate education of staff infection prevention practices completed May 10, 2010.<br><br>o Staff will utilize mask during working shift to prevent spread of germs | |

6/18/10

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

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| F 441 | Continued From page 16<br>two non-sample residents (#37, #69). The observation also showed she did not clean the glucometer between resident uses. Interview with the LPN on 5/4/10 at 5:10 PM revealed the glucometers were cleaned by the night shift every 24 hours.<br><br>3. Observation on 5/4/10 at 4:40 PM showed RN #3 used a glucometer to perform glucose tests on three non-sample residents (#23, #24, #70). The observation also showed she did not clean the glucometer between resident uses. During an interview with the RN immediately after the observation, she stated the night shift cleaned the glucometers every 24 hours.<br><br>4. Observation on 5/5/10 at 4:10 PM showed LPN #2 used a glucometer on resident non-sample resident #122 to perform a glucose test. Immediately after the test, the LPN cleaned the area around the insertion site for glucose monitoring strips with an alcohol pad. During an interview at that time, the LPN stated she cleaned the glucose monitor with an alcohol pad between each test. She further stated the night shift cleaned glucometers every 24 hours.<br><br>5. Observation on 5/5/10 at 4:25 PM showed RN #4 used a glucometer to perform glucose tests on two non- sample residents (#1, #5). Immediately after the test, the RN cleaned the area around the insertion site for glucose monitoring strips with an alcohol pad. During an interview immediately after the observation, the RN stated she cleaned the glucose monitor with an alcohol pad between each test. She further stated the night shift cleaned glucometers every 24 hours.<br><br>6. Observation on 5/5/10 at 5 PM showed LPN #3 | F 441 | F441 Continued from page 15.<br>during duration of symptoms.<br><br>• Infection control/safety education will be completed by June 20, 2010.<br><br>• A policy revision to include cleaning process will be completed by June 20, 2010.<br><br>100% of instruments will be cleaned according to manufacturer recommendations.<br><br>Nursing Leadership will monitor 30 observations per month and report monthly to QA committee. Immediate education and intervention will occur for all discrepancies. All deviations from cleaning policy will be immediately corrected. | |

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

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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 _____ | 05/06/2010 |

| 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 441 | Continued From page 17<br>used a glucometer to perform glucose tests on two non-sample residents (#6, #77). Between tests, the LPN cleaned the area around the insertion site for glucose monitoring strips with an alcohol pad. After the two tests, the LPN cleaned the entire outside of the glucometer with a Super Sani Cloth wipe.<br><br>During an interview with the DON on 5/6/10 at 12:55 PM, she stated staff should cleanse glucometers after each use. The DON further stated she was unsure what the manufacturer recommended. Review of the manufacturer information provided by the DON on 5/10/10 at 4:09 PM revealed, alcohol was not approved for cleaning the glucometers. The meters were to be cleaned with a cloth dampened with a 10% bleach solution or disinfectant wipe.<br><br>According to the Centers for Disease Control recommendations, "Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected." Recommended infection-control and safe injection practices to prevent patient-to-patient transmission of bloodborne pathogens. Centers for Disease Control website. 2005. Available at: www.cdc.gov/hepatitis/Resources/OrderPubs/HealthProf/PrevP-to-PTransHandout_Eng.pdf. Accessed May 10, 2010.<br><br>7. Observation on 5/6/10 at 11:25 AM showed dietary staff #1 was wearing a surgical mask while serving the resident meals in the facility's secured unit. She stated she had a cold with runny nose, sneezing and coughing. She further | F 441 | | |

6/18/10

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| F 441 | Continued From page 18<br>revealed she had had these symptoms since Monday (5/3/10). Previous observations on 5/3/10 at 2:15 PM and 5/5/10 at 9:10 AM revealed dietary staff #1 was working in the kitchen and was not wearing any mask. Interview with the infection control coordinator on 5/6/10 at 12 PM revealed the staff member should have been wearing the mask in all locations of the facility as long as symptoms were present. | F 441 | | |
| F 492 SS=E | 483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD<br><br>The facility must oporate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and medical record review, the facility failed to ensure CNAs performed tasks for which they were qualified and within their scope of practice for 6 (#15, #31, #34, #48, #49, #118) of 8 sample residents who had side rail assessments performed. The findings were:<br><br>Review of the side rail assessments for sample residents #31, #34, #15, #48, #49, #118 revealed they were performed by CNA #1. Interview with the DON on 5/6/10 at 3 PM confirmed the assessments should be completed by a licensed nurse. According to the July 2005 Nursing Practice Act and Administrative Rules and Regulations November 2003, performing an assessment is not within the scope of the practice | F 492 | F492<br>Pioneer Manor will ensure each CNA performs tasks in which they are qualified to complete. In addition, Pioneer Manor will ensure each CNA is within their scope of practice. This will be accomplished by:<br><br>#31, #34, #48, #49, #118<br>• Side rail assessments completed by RN and assessment findings incorporated into care plan; Care Planning meetings to include side rail assessment and plan for use of side rails as appropriate.<br><br>• Restorative Nurse or designee to evaluate side rails assessment during MDS data collection.<br><br>• Leadership to audit 10 charts per week and findings/interventions will be reflected on the resident's care plan and reported monthly to QA committee. | 6/20/10 |

6/8/10

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| F 492 | Continued From page 19<br>for CNAs<br><br>Refer to Federal citation F323 for additional details related to inadequate side rail assessments for these residents. | F 492 | F492 Continued from page 19.<br><br>• All specific staff will be educated on or before June 20, 2010. | |
| F 496 SS=E | 483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING<br><br>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.<br><br>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.<br><br>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. | F 496 | F496<br>Pioneer Manor will ensure the facility prefers registry verification on each CNA and that the individual has met competency requirements before allowing the individual to serve as a nurse aide. This will be accomplished by:<br><br>• #2,#3,#4 Records verified through the State CNA registry.<br><br>• All CNA staff will have nurse aide registry verification. Future employed staff will have nurse aide registry verification as part of initial reference check prior to employment and report put in personnel file.<br><br>100% of CNAs employed will have nurse aide registry verification. HR will generate a report for all new CNA staff and DON to report at monthly QA meeting.<br><br>All specific staff will be inserviced on or before June 20, 2010. | 6/20/10 |

6/8/10

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| F 496 | Continued From page 20<br>This REQUIREMENT is not met as evidenced by:<br>Based on personnel record review and staff interview, the facility failed to ensure 3 of 3 CNAs (#2, #3, #4) whose records were reviewed were safe and competent employees. The findings were:<br><br>Review of the personnel records for CNAs #2, #3, #4 showed the facility failed to check the State CNA Registry. During an interview with the DON on 5/6/10 at 12:30 PM, she confirmed the facility had failed to check the State CNA Registry for these CNAs prior to employment. | F 496 | | |