POC accepted 3/19/10

Janelle Condon, OTR/L

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

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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
	535030	A. BUILDING ____ B. WING ____	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

(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 151 SS=E	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interviews, the facility failed to allow 2 of 11 sample residents (#8, #41) to exercise their rights without interference from staff. The findings were: 1. During a group interview with residents on 2/23/10 at 1 PM, the following concerns were identified regarding actions performed by the facility which limited the choice and independence of residents: a. Resident #41 said he wanted to keep his chewing tobacco with him, so he could use it whenever he wanted. The resident stated the tobacco was kept by nursing staff, and he was not allowed to keep it. The resident asked, "Why do I need to ask for it?" b. Resident #8 stated s/he had dry skin and had mineral oil that s/he used. The resident stated the facility took the mineral oil out of his/her room because it "wasn't allowed," and the mineral oil was now kept by nursing staff. The resident noted that s/he had a locked drawer in his/her room where it could have been kept. c. Three residents stated they were "not allowed" to keep Tums (antacids) in their rooms anymore.	F 151	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-151 Right to Exercise Rights** **Corrective Measures for Identified Residents:** On 3/10/10 the SKOAL was returned to resident #41. On 2/26/10 nurses met with resident #8 and offered to place the mineral oil in the resident's room, but the offer was declined. On 3/17/10 the ED and the District nurse apologized to resident #8 and offered to return the mineral oil. Resident #8 declined the offer. On 3/17/10 the District nurse extended apologies to the Resident Council regarding the removal of items from their rooms, infringing on their rights, and showing disrespect by removing any personal items they wished to keep. Discussion was held surrounding safety, assessments and physician orders.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	3/19/2010

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. Spoke to Yvonne Jakel, ED on 3/19/10 @ 10:10 AM

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	535038	A. BUILDING _____ B. WING _____	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 15TH STREET RAWLINS, WY 82301

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F 161	Continued From page 1 d. One resident stated the facility said s/he could no longer have over-the-counter medications in his/her room. However, the resident stated a/he was finally able to have those items in his/her room again after "going round and round" with the facility. e. When asked if anyone from the facility had discussed this with the residents prior to removing the items from the rooms, all of the aforementioned said no. The residents also stated that because of recent thefts, all the residents were offered a locked drawer in their room, which the residents thought could also be used to secure potentially unsafe items. 2. Interview with licensed practical nurse (LPN) #1 on 2/25/10 at 9:10 AM revealed the facility staff went to all resident rooms in January 2010 (date uncertain) and took any items deemed to be unsafe. 3. Refer to F 241 for additional details regarding the facility's failure to allow resident #41 to keep his chewing tobacco. The resident's identity and his wishes were revealed to the facility staff during the exit interview on 2/25/10 at 11 AM. On 2/26/10, the facility submitted additional faxed information to the Office of Healthcare Licensing and Surveys. One fax was a hand written note from the resident's daughter, dated 2/25/10 (the day the surveyors exited). The note stated the resident and daughter had been informed the resident's chewing tobacco would be kept at the nurses' station, and they had agreed to this on 12/19/09, the day the resident was admitted to the facility. The note was signed by the resident's daughter, but not by the resident. Review of the 12/29/09 Minimum Data Set (MDS) assessment revealed the resident had modified independence	F 161	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Identification of other residents:** Through an "Angel Care" audit residents will be asked if they have had anything removed from their rooms that they would like to keep. Any desires expressed by residents will be assessed for safety purposes and physician orders obtained as needed. Questions were queried of the residents at the resident council meeting on 3/17/10 to determine if anyone had any items removed and would like them replaced. They were encouraged to speak to us privately to make their wishes known if they desired. **Measures/Systemic Changes:** The SDC/ Designee will conduct training of staff including kitchen staff by April 11, 2010 regarding resident's choice and resident rights. This will include keeping personal items with residents that would otherwise have been kept in a locked drawer by nursing staff.	

4/13/10

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	535036	A. BUILDING _____ B. WING _____	02/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	842 16TH STREET RAWLINS, WY 82301

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F 161	Continued From page 2 In cognition and was independent in decision making. Interview on 2/25/10 at 8:18 AM with the resident revealed he was alert and oriented. 4. Refer to F 241 for additional details regarding the facility's failure to allow resident #8 to keep mineral oil in his/her room. On 2/25/10 at 11 AM the identity of the resident was made known to facility staff at an exit interview. On 2/26/10 the facility faxed additional information to the Office of Healthcare Licensing and Surveys. The facility faxed a progress note which documented that on 2/25/10 at 6:50 PM (7.5 hours after surveyors exited the facility) the facility approached the resident about the mineral oil. The note stated that now the resident preferred to have nursing staff keep the mineral oil; the note in the resident's medical record had been signed by staff and the resident.	F 151	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident Council members will be queried monthly to ensure they have been able to exercise their rights without interference from staff. Identified concerns will be handled through the facilities grievance program. **Monitoring:** Identified concerns resulting from Angel Care questions and Resident Council discussions will be brought to Performance Improvement Committee (PIC) by the ED/Designee monthly for review and recommendations. **Date of compliance: April 11, 2010** **F-226 Abuse Policies:** **Corrective Measures for identified residents:** On February 26, 2010 the reference checks for the cited employee #2 were completed.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on facility policy, personnel records review, and staff interview, the facility failed to complete reference checks before employment for 1 of 5 employees (#2) reviewed. The findings were: Review of the facility's "Employee Background and Screening" policy revealed, "5.b. Employment is conditional upon successful completion of the	F 226		4/11/10

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 19TH STREET RAWLINS, WY 82301

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F 226	Continued From page 3 reference check." The following concerns were noted: a. Personnel record review on 2/24/10 at 11 AM for employee #2, who worked in the dietary department, revealed a date of hire of 1/13/10. Further review revealed no documentation of a reference check for the employee. b. Interview on 2/24/10 at 11:15 AM with the personnel director confirmed she had not obtained a reference check for this employee.	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Identification of Other residents:**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 medical record review, and staff and resident interviews, the facility failed to ensure dignity was maintained for 2 of 11 sample residents (#6 and #41). The findings were: 1. During a group interview on 02/23/10 at 1 PM, resident #41 said s/he wanted to keep his/her tobacco products with him/her, so s/he could use it whenever s/he wanted. The resident stated the tobacco was kept by nursing staff, and s/he was not allowed to keep it. The resident asked,"Why do I need to ask for it?" Medical record review for this resident revealed an admission Minimum Data Set (MDS) assessment signed as completed on 12/29/09. The MDS assessment revealed the resident had modified independence in cognition and was independent in decision making. Interview on 2/24/10 at 4:05 PM with licensed practical nurse (LPN) #1 revealed the	F 241	The facility will complete a review of employee records to determine if there are any missing reference checks and references will be completed as needed. **Measures/Systemic Changes:** Each Department Manager will be responsible for the completion of the reference checks for their departments. The Payroll-Benefits Coordinator (PBC) will be the gatekeeper for the files and will confirm that all necessary documentation is present. The PBC will notify respective managers as needed of additional record requirements. **Monitoring:** The PBC will keep a log of all new hires and report any identified concerns monthly to the Performance Improvement Committee (PIC) for review and recommendations. **Date of Compliance: April 11, 2010**	4/11/10

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 10TH STREET RAWLINS, WY 82301

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F 226	Continued From page 3 reference check." The following concerns were noted: a. Personnel record review on 2/24/10 at 11 AM for employee #4, who worked in the dietary department, revealed a date of hire of 1/13/10. Further review revealed no documentation of a reference check for the employee. b. Interview on 2/24/10 at 11:15 AM with the personnel director confirmed she had not obtained a reference check for this employee.	F 226	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-241 Dignity**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 medical record review, and staff and resident interviews, the facility failed to ensure dignity was maintained for 2 of 11 sample residents (#8 and #41). The findings were: 1. During a group interview on 02/23/10 at 1 PM, resident #41 said s/he wanted to keep his/her tobacco products with him/her, so s/he could use it whenever s/he wanted. The resident stated the tobacco was kept by nursing staff, and s/he was not allowed to keep it. The resident asked,"Why do I need to ask for it?" Medical record review for this resident revealed an admission Minimum Data Set (MDS) assessment signed as completed on 12/29/09. The MDS assessment revealed the resident had modified independence in cognition and was independent in decision making. Interview on 2/24/10 at 4:05 PM with licensed practical nurse (LPN) #1 revealed the	F 241	**Corrective Action for Identified Residents:** On 3/10/10 the SKOAL was returned to resident #41. On 2/26/10 nurses met with resident #8 and offered to place the mineral oil in her room. The resident declined the offer. On 3/17/10 the Executive Director and the District nurse extended apologies to the resident and again offered to replace the mineral oil. The offer was declined. **Identification of Other Residents:** Through an "Angel Care" audit residents will be asked if they have had any items that were taken from their rooms that they would like to keep at the bedside. Any desires expressed by residents will be assessed for safety purposes as needed.	

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	842 16TH STREET RAWLINS, WY 82301

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F 241	Continued From page 4 resident used tobacco products and his/her tobacco products were kept by the nurses at the nurses' station. Further interview revealed the reason the nurses kept the resident's tobacco was because the resident spilled the tobacco products when opened them. Interview on 2/25/10 at 8:15 AM with the resident revealed s/he would like to keep the tobacco products, but was told there was a rule against it. The resident went on to say s/he wanted to keep the tobacco products because a lot of times the nurses were not at the nurses station, and s/he had to wait until they weren't busy to get the tobacco products. 2. During a group interview on 02/23/10 at 1 PM, resident #8 stated the facility took the mineral oil out of his/her room because it "wasn't allowed," and was now being kept by nursing staff. The resident noted that s/he had a locked drawer in his/her room where the oil could be kept. Review of the 12/28/09 annual MDS assessment showed this resident was independent for daily decision making. During an interview on 2/24/10 at 9:20 AM, the resident stated that facility staff came to his/her room sometime in January 2010 and confiscated his/her bottle of mineral oil. The resident stated the staff (uncertain which staff member) commented that certain items, mineral oil included, had to be kept by nursing staff for safety. During the interview, the resident produced a key to a locked drawer in his/her bedside stand. The resident then stated s/he preferred to have the mineral oil in the locked drawer in his/her room. Interview with LPN #1 on 2/25/10 at 9:10 AM revealed the facility staff went to all resident rooms in January 2010 (date uncertain) and secured any items thought to be unsafe.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Discussion was held with the residents at the resident council meeting on 3/17/10 regarding the resident's right and dignity to keep items in their room and apologies were extended for infringing on their rights and any disrespect shown by removal of items. Offers to replace taken items were extended. **Measures/Systemic Changes to Prevent Recurrence:** The staff will be re-educated on resident rights and the removal of items from their rooms. This will include the treatment of our residents with the utmost dignity and respect. Discussion will be held at Resident Council monthly to determine that their rights are being respected and that they are treated with dignity. **Monitoring:** Concerns identified per the Angel Care questions and monthly Resident Council meetings will be brought to the PIC by the ED/Designee for review and recommendations. **Date of Compliance: April 11, 2010**	4/11/10

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

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F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to ensure the activities program was directed by a qualified professional. The findings were: According to documentation provided by the facility, the activity director was identified as employee #1. Review of the Long Term Care Facility Application for Medicare and Medicaid (CMS-671), completed by the administrator, revealed the facility did not have a qualified activities professional. During an interview on 2/24/10 at 1:40 PM, employee #1 stated she has been the activity director since "about August." She stated she was in the dietary department prior to that. Employee #1 further stated she had not completed an approved State course for activity professionals.	F 249	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-249 Qualifications of Activity Professional:** **Corrective Action for Identified Concern:** A qualified professional will be hired for the role of Activities Director. The current Activities Director will be enrolled in a training course for certification of Activities Professionals. That individual will function as the Activities Assistant. **Identification of Others:** Facility Activities Directors will meet the mandatory requirements as per regulation. **Measures/Systemic Changes:** Future Activities Directors will be required to meet the regulatory requirements. **Monitoring:** The ED will bring identified concerns to the monthly PIC meeting for review and recommendations. **Date of Compliance: April 11, 2010**	4/11/10

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F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to accurately reflect the resident's status on the Minimum Data Set (MDS) assessment for 5 of 11 sample residents (#2, #13, #35, #41, and #42). The findings were:	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-278 Assessment Accuracy** **Corrective Action for Identified Residents:** Facility MDSs will be audited by the IDT (Interdisciplinary Team) to confirm accuracy. Any discrepancies will be addressed per RAI protocol. **Identification of Other Residents:** MDS corrections were completed for residents #2, #13, #35, #41 and #42 on February 26, 2010. **Measures/Systemic Changes:** Facility staff that participates in the RAI process will be re-trained regarding MDS accuracy. Facility MDS's will be reviewed for accuracy by each department manager, MDS coordinator and RN Coordinator prior to submission. Corrections will be made as needed. A log will be kept of needed corrections.	

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

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F 278	Continued From page 7 1. Review of the 1/11/10 annual MDS assessment showed resident #13 was coded as having mild pain less than daily. However, on 2/24/10 at 4:45 PM the MDS coordinator reviewed pain flowsheets from that time period with the surveyor. After reviewing the documentation, the MDS coordinator stated the resident's pain should have been coded "2/2" (moderate pain daily). 2. Medical record review for resident #2 revealed an annual MDS assessment signed as completed on 1/28/10. According to the MDS assessment, there were no skin issues identified. However, review of the weekly non-pressure skin condition reports and physician orders in January 2010 revealed the resident had partial thickness openings on his/her legs. Interview on 2/24/10 at 9:45 AM with the MDS coordinator confirmed the resident had skin ulcers during the assessment period of the MDS, but the resident's skin condition was not accurately reflected by the MDS assessment. 3. Medical record review for resident #41 revealed an admission MDS signed as completed on 12/29/10. There were no skin issues identified on the MDS assessment. However, medical record review revealed a physician progress note dated 12/24/10 which stated the resident had a "..deep ulcer right lateral ankle probably to the bone..." In addition, a weekly pressure ulcer condition report dated 12/19/09 revealed the resident had a Stage III ulcer on his right ankle. Interview on 2/24/10 at 9:45 AM with the MDS coordinator revealed she did not see the weekly pressure ulcer condition report and confirmed the MDS assessment was miscoded for the resident's skin issues. 4. Medical record review for resident #42	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Monitoring:** The MDS Coordinator will collate information obtained from the logs and report identified MDS Accuracy concerns to the PIC each month for 3 months or until the issue is resolved. **Date of Compliance: April 11, 2010**	4/11/10

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

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	535036	A. BUILDING _____ B. WING _____	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

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F 278	Continued From page 8 revealed a quarterly MDS assessment signed as having been completed on 1/18/10. Review of the assessment revealed the resident was coded as not having received any antianxiety medications during the seven day assessment period. However, review of the January 2010 medication administration record revealed the resident received clonazepam (an antianxiety medication) daily. Interview on 2/24/10 at 9:45 AM with the MDS coordinator confirmed she had not accurately recorded the antianxiety medication on the resident's MDS assessment. 5. Review of the 12/28/09 annual MDS assessment for resident #35 showed s/he had a history of pressure ulcers that were all resolved. Review of the resident's Weekly Pressure Ulcer Condition Report from 12/18/09 through 1/7/10 showed the resident had a pressure ulcer on the left lateral foot that measured 0.6 centimeters in size, was a stage II, and was distinct and clearly visible. During an interview with the MDS coordinator on 2/26/10 at 10 AM, it was revealed that the MDS coding was incorrect.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-282 Care Plan** **Corrective Action for Identified Residents:** The staff caring for resident #22 was re-educated regarding the care plan for check and change. **Identification of Other Residents:** Residents at risk will be identified via an audit of care plans for incontinence. **Measures/Systemic Changes:**	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 1 of 11 sample residents (#22).	F 282	The staff will be re-educated on how to follow care plans and understand toileting plans. **Monitoring:** The DNS/ Designee will conduct random weekly observations for 3 months to ensure toileting care plans are being followed and report findings to PIC monthly. **Date of Compliance: April 11, 2010**	4/11/10

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F 282	Continued From page 9 The findings were: Refer to F 315 for details regarding the facility's failure to follow the care plan for incontinence for resident #22.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interviews, the facility failed to effectively control pain for 1 of 6 sample residents (#13) with pain, which resulted in the resident experiencing pain at a higher level than was acceptable to him/her. The findings were: 1. Review of pain assessments, dated 2/6/10 and 1/6/10, revealed resident #13 had pain in all joints due to arthritis. The assessments documented the resident's acceptable level of pain was "2" on a scale of 0 to 10 (0 being no pain and 10 hurting the worst). Review of physician's orders showed the resident received Celebrex 200 milligrams (mg) routinely every morning for pain. In addition, Tylenol 1000 mg every 4 to 6 hours had been ordered as needed for pain. The following concerns were identified: a. Review of pain monitoring flowsheets from December 2009 to February 2010 revealed the	F 309	**F-309 Quality of Care:** **Corrective Measures for Identified Residents:** Resident #13 was re-assessed with a new pain assessment. The resident's physician was notified about pain and orders were received for routine pain medication. The resident's pain is now managed at an acceptable level to the resident. **Identification of Other Residents:** A new pain assessment will be conducted on all residents to determine their acceptable level of pain and confirm that their current program is appropriate. Adjustments to their pain program will be made as necessary to validate that their pain is managed at an acceptable level. **Measures/Systemic Changes:** The nursing staff will be re-educated about conducting pain assessments and managing pain of the residents. The DNS/Designee will conduct audits weekly to validate that the residents' pain is being managed at an acceptable level. Corrective action will be taken as appropriate.	

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F 309	Continued From page 10 resident requested and received Tylenol 1000 mg almost every night between 7:30 PM and 8:45 PM. The resident's level of pain prior to the medication was 6 or 7 (on a scale of 0 to 10). However, the resident's pain level after receiving the medication was rated from 3 to 6. In 77 out of 77 entries (100%), the resident's post medication pain level was rated higher than 2 (which was documented as the resident's acceptable level of pain). Furthermore, 65 out of the 77 entries (84%) documented the resident's post medication pain level was at least a 5 or 6. b. During an interview on 2/24/10 at 4 PM, the resident stated s/he gets pain at night at about 8 PM. The resident said the Tylenol "eases" the pain, but that s/he still hurts "pretty bad." The resident stated when s/he has pain, it interferes with his/her mobility and activity level. Furthermore, the resident said s/he used to take "something stronger," but the facility "told me I couldn't have it anymore, because I got too much." The resident stated the other medication worked better for his/her pain. A second interview, conducted by another surveyor, on 2/25/10 at 8:50 AM revealed the resident had arthritis and, "...it really hurts." The resident went on to say s/he took Celebrex and Tylenol and the Tylenol worked "so, so." The resident further revealed s/he used to take something stronger, "...but they took it away because they thought I took it too much, and I would get hooked. It worked better than the Tylenol." Review of the medical record showed the resident used to receive Darvocet N-100 until the pharmacist recommended the physician discontinue the medication and replace it with the Tylenol. The physician discontinued the Darvocet in November 2009. c. Review of the medical record showed no	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Monitoring:** The DNS/Designee will report findings to the PIC monthly for review and recommendations. **Date of Compliance: April 11, 2010**	4/11/10

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F 309	Continued From page 11 evidence the facility had re-evaluated the resident's pain management plan to ensure the resident received an acceptable level of pain relief. During an interview on 2/25/10 at 9:35 AM, the director of nursing (DON) stated a pain level of 5 or 6 after receiving an analgesic medication was "not acceptable." During an interview with the DON and district director of clinical operations (DDCO) on 2/25/10 at 10:35 AM, the DDCO stated, "You won't find in the medical record that we communicated with the physician regarding [the resident's] pain."	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-315 Incontinence:** **Corrective Measures for Identified Residents:** Staff caring for resident #22 was retrained on the check and change plan for this resident. Staff caring for resident #30 was retrained on appropriate handling and placement of the catheter bag during transfers and care. **Identification of Other Residents:** Residents at risk include those on toileting plans/programs and those with catheters. **Measures/Systemic Changes:** Staff will be retrained on following toileting plans with emphasis on check and change plans and the proper handling of catheter bags during transfers and cares.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care in a manner which would keep the 1 of 3 sample incontinent residents (#22) clean and dry. In addition, the facility failed to provide care in a manner that would prevent urinary tract infections for 1 of 3 sample residents (#30) who had urinary catheters. The findings were: 1. Review of the 1/22/10 quarterly Minimum Data	F 315		

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F 315	Continued From page 12 Set (MDS) assessment showed resident #22 was cognitively impaired and was incontinent of bladder. Review of the 1/18/10 quarterly bladder assessment revealed the resident had a diminished perception of the need to urinate, was unable to communicate toileting needs, and "does not always recognize need to void." The current care plan (dated 1/19/10) instructed staff to "check and change frequently...keep clean and dry as able." The following concerns were identified: a. Observation on 2/23/10 showed the resident was not checked for incontinence from 7:40 AM until 11:20 AM (3 hours 40 minutes). During that time, certified nurse aide (CNA) #1 asked the resident if s/he needed to use the bathroom, and the resident replied "no." At 11:20 AM, when CNAs #1 and #2 checked the resident for incontinence, the resident had been incontinent of bladder. At 11:29 AM, CNA #1 stated the resident did not always know when s/he needed to go to the bathroom. b. During an interview on 2/25/10 at 9:35 AM, the director of nursing (DON) stated staff were instructed to check and change the resident at least every two hours. The DON stated that since the resident did not always know when s/he needed to void, staff were supposed to check the resident for incontinence. The DON stated that check and change did not mean asking the resident if s/he needed to go, but rather actually checking the resident for incontinence. 2. Observation on 2/22/10 at 4:55 PM revealed CNA #3 and nurse aide (NA) #1 provided personal care to resident #30 in bed and then transferred the resident into a wheelchair. While providing care the staff member placed the uncovered urine drainage bag on the floor. During	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Random observations of staff toileting residents and handling catheter bags will be conducted weekly by the DNS/Designee to confirm that appropriate care is being provided. Concerns will be immediately addressed. **Monitoring:** Results of observations will be reported by the DNS/Designee to the PIC monthly for review for 3 months. **Date of Compliance: April 11, 2010**	4/11/10

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F 315	Continued From page 13 an interview on 2/26/10 at 10:20 AM, the infection control nurse stated catheter bags should be covered, and uncovered bags should not be placed on the floor.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 386 SS=D	483.40(h) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain a progress note from the physician for a visit with 1 of 11 sample residents (#41). The findings were: Medical record review for resident #41 revealed s/he was admitted to the facility on 12/19/09. In the medical record, there were two physician progress notes dated 12/24/09. Medical record review revealed no other physician progress notes. On 2/26/10 at 10:55 AM, the director of nursing (DON) provided a copy of a prescription for antibiotics written by the physician for the resident dated 1/21/10. Interview with the DON at that time revealed the resident saw the physician on 1/21/10, but confirmed there were no physician progress notes for that visit.	F 386	**F-386 Physician Visits to Review Residents** **Corrective Action for Identified Residents:** A progress note for resident #41 for the physician visit on 1/21/10 was placed in the medical record. A new progress note was written on March 9, 2010. **Identification of Other Residents:** Facility records will be audited to confirm current physician progress notes for each visit. Any identified concerns will be addressed with the physician for correction. **Measures/Systemic Changes:** The Health Information Manager (HIM)/Designee will audit records each month and notify the physicians of missing documentation of their visits. If proper documentation is not achieved then concerns will be brought to the physician and then to the Medical Director for intervention.	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387		

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	842 16TH STREET RAWLINS, WY 82301

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F 315	Continued From page 13 an interview on 2/25/10 at 10:20 AM, the infection control nurse stated catheter bags should be covered, and uncovered bags should not be placed on the floor.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain a progress note from the physician for a visit with 1 of 11 sample residents (#41). The findings were: Medical record review for resident #41 revealed s/he was admitted to the facility on 12/19/09. In the medical record, there were two physician progress notes dated 12/24/09. Medical record review revealed no other physician progress notes. On 2/25/10 at 10:55 AM, the director of nursing (DON) provided a copy of a prescription for antibiotics written by the physician for the resident dated 1/21/10. Interview with the DON at that time revealed the resident saw the physician on 1/21/10, but confirmed there were no physician progress notes for that visit.	F 386	**Monitoring:** The HIM/Designee will review findings related to physician documentation each month at the PIC for recommendations. **Date of Compliance: April 11, 2010** **F-387 Frequency of Physician Visits** **Corrective Action for Identified Residents:** The physician for resident #8 and #22 completed and documented his visit on March 10, 2010. **Identification of Other Residents:** Facility records will be audited for current physician visits. Any noncompliance with visits will be addressed with the physician for correction. **Measures/Systemic Changes:**	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	F 387		

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F 387	Continued From page 14 The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to ensure a physician or midlevel practitioner visited at least once every 60 days as required for 2 of 11 sample residents (#8, #22). The findings were: 1. Review of the medical record showed resident #22 had not had a physician or midlevel practitioner visit for at least four months prior to 12/24/09. When asked to provide evidence of additional physician visits, the director of nursing (DON) provided a piece of paper which stated the resident went to the emergency room on 11/5/09. However, review of the emergency room discharge instructions dated 11/5/09 revealed the examination and treatment was rendered on an emergency basis, and was "not intended to be a substitute for an effort to provide complete medical care." 2. Review of the medical record for resident #8 showed the physician or midlevel practitioner had not visited the resident for at least four months before 12/24/09. During an interview on 2/24/10	F 387	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Health Information Manager (HIM)/ Designee will audit records each month and notify the physicians of required visits. If the physician is not able to meet the visitation needs, an appointment at the physician office will occur. **Monitoring:** Physician visits will be discussed each month at the PIC. Concerns identified by the HIM/Designee will be reviewed with the team and Medical Director for recommendations and follow-up. **Date of Compliance: April 11, 2010**	4/19/10

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F 387	Continued From page 15 at 4:20 PM, the administrator verified that the resident had not had a physician visit for at least four months before 12/24/10.	F 387	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	**F-441 Infection Control Program** **Corrective Measures for Identified residents:** Antibiotics for resident #33 were initiated on 10/28/09. Antibiotics for resident #30 were started on 11/18/09 and 2/3/10. Resident #41 began bactrim on 2/8/10 and vancomycin treatment on 2/15/10 after the placement of a central line by the surgeon. Staff caring for resident #30 will be retrained on the proper handling of the catheter bag to prevent infection. **Identification of Other residents:** The Infection Control nurse/ Designee will audit records to confirm timely initiation of antibiotics for identified infections. Corrective action will be taken as needed. Residents with catheters are at risk for mishandling of catheter bags.	

4/19/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 16TH STREET RAWLINS, WY 82301

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F 441	Continued From page 16 infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to follow up on laboratory results to ensure timely antibiotic therapy for 3 of 7 residents (#22, #30, #41) with an infection that required antibiotic therapy. In addition, the facility failed to ensure 1 of 3 sample residents (#30) with catheters had the drainage bag handled in a clean, sanitary manner. The findings were: 1. The following concerns were noted regarding follow-up of laboratory results: a. Review of the medical record for resident #33 showed a urine culture collected on 10/20/09. The laboratory results showed the resident's urine was positive for more than 100,000 colonies per ml of the bacterium, Escherichia coli. The record who showed the results were faxed to the physician on the date of receipt. On 10/26/10, after no response from the physician, the results were re-faxed. That time the physician responded with an order for the antibiotic Augmentin 875 mg twice a day for seven days. Interview with the infection control nurse on 2/25/10 at 8:30 AM revealed the facility normally just re-faxes culture information (instead of calling) when there has been no physician response. In this particular instance this practice resulted in a delay of six days before the antibiotic therapy was initiated. b. Review of the medical record for resident #30 showed a urine culture was collected on 1/26/10	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Measures/Systemic Changes:** Nurses will be retrained re: timely response to culture reports. This will include the phoning of physicians in addition to the faxing of culture results. Methods of notification will be documented and follow-up will occur until a response is obtained. Audits will be conducted weekly by the Infection Control nurse/designee to confirm timely notification of physicians and initiation of antibiotics. Concerns will be immediately addressed. Staff will be retrained on the appropriate handling of catheter bags during transfers and care to prevent infection. Weekly random observations of catheter bag handling during transfers and care will be conducted by the DNS/Infection Control nurse/Designee. **Monitoring:** The Infection Control nurse will report results of audits and observations to the PIC monthly for review and recommendations for 3 months. **Date of Compliance: April 11, 2010**	4/19/10

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	835836	A. BUILDING _____ B. WING _____	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	842 16TH STREET RAWLINS, WY 82301

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F 441	Continued From page 17 and completed on 1/29/10. The results, greater than 100,000 colonies per ml of the bacterium, Pseudomonas aeruginosa, were faxed to the physician's office. There was no response from the physician and the culture results were re-faxed on 2/3/10, at which time the physician ordered Ciprofloxacin (an antibiotic) 500 mg twice a day for ten days. Medical record review also showed a urine culture collected on 11/09/09 and completed on 11/12/09. The results, 10,000-50,000 colonies per milliliter of the bacterium, Enterococcus faecalis, were faxed to the physician's office with no response. The results were re-faxed on 11/18/09, and the physician ordered the antibiotic Macrobid 100 mg twice a day for ten days. During an interview with the infection control nurse on 2/25/10 at 8:30 AM, revealed the facility did not follow-up on the 1/29/10 culture until 2/3/10, resulting in a five day period before the resident received a physician's order for antibiotic therapy. In addition, the interview revealed the facility failed to follow-up on the 11/12/09 culture until 11/18/09, which resulted in a six day period before the resident received a physician's order for antibiotic therapy. c. Review of physician orders showed that on 1/22/10 resident #41 was ordered the antibiotic Ciprofloxacin 500 mg twice per day. Further medical record review showed the resident's decubitus ulcer on the right ankle was debrided and cultured on 1/28/10. The results, dated 1/28/10, showed the bacterium Methicillin Resistant Staphylococcus aureus (MRSA), which was resistant to the antibiotic the resident was receiving at the time (Ciprofloxacin). Interview with the infection control nurse on 2/25/10 at 8:30 AM showed the facility did not get results of the culture and call the physician until 2/8/10 because	F 441		

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SOUTH CENTRAL WYO HEALTHCARE & REHABILITATION CTR	542 18TH STREET RAWLINS, WY 82301

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F 441	Continued From page 18 "the result was obtained at another facility." At that time the antibiotic Bactrim (an antibiotic) was ordered at regular strength to be taken orally once daily, until a central line could be placed for the antibiotic Vancomycin. The facility failed to obtain and report the culture results in a timely manner, which resulted in the resident not receiving the appropriate antibiotic for eleven days. 2. Refer to F 315 for details regarding the failure of the staff to handle the catheter bag of resident #30 in a manner that would prevent urinary tract infections.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-465 Administration; Safe/Functional/Sanitary/Comfortable Environment** **Corrective Measure for identified issue:** The backflow device in the Beauty Shop was replaced on March 10, 2010.	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide safety equipment to prevent back siphonage of contaminated water into the potable water system of the building. The findings were: Observation of the facility beauty shop on 2/25/10 at 9 AM revealed the sink did not have a backflow device. Interview with the maintenance director at that time confirmed the sink did not have a backflow device or comparable safety feature.	F 465	**Identification of Others:** Sinks in the facility will be observed for appropriate backflow device placement. Necessary corrections will be made. **Measures/Systemic Changes:** Re-education will be given to the Maintenance supervisor regarding the replacement of backflow devices when sinks or plumbing is changed. Observations of sinks for backflow devices will be performed monthly x 3. **Monitoring:** Results of observations will be reported to the PIC monthly x 3 for review and recommendations. **Date of Compliance: April 11, 2010**	4/11/10