STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 05/12/2011

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 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing LPN-Licensed Practical Nurse MDS- Minimum Data Set RN-Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		06/26/11
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	**F 272 Comprehensive assessment** Pioneer Manor will ensure the facility conducts initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident. This will be accomplished by; (#5, #107, #17, #78, #21) Resident # 5 • CAA reflects incorrect resident with nonnutrition information. Issue with software identified, corrected CAA for correct resident. Registered Dietitian complete current nutrition assessment with collaboration from CDM and signs CAA 06/06/11 Resident # 107 • Registered Dietitian complete current nutrition assessment with collaboration from CDM and signs CAA 06/01/11 Resident # 17 • Registered Dietitian complete current nutrition assessment with collaboration from CDM and signs CAA 06/01/11 Resident #78 • Registered Dietitian complete current nutrition assessment with collaboration from CDM and signs CAA 06/01/11	

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

Administrator 6-3-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
JUN 06 2011
Wyoming Department of Health

This POC accepted on 6/12/11 by Betsy Jay and the administrator (Erik Bjordahl).

Office of Healthcare Licensing and Surveys

Maddy 6/17/11

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F 272	Continued From page 1 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by; Based on medical record review and staff interview, the facility failed to ensure a qualified professional completed nutritional assessments in the area of nutrition for 5 of 10 sample residents (#5, #17, #21, #78, #107). The findings were: 1. Review of the 12/22/10 quarterly MDS assessment for resident #5 showed s/he needed further assessment in the area of nutrition. Review of the 12/22/10 CAA for nutrition showed the assessments were signed as completed by certified dietary manager (CDM) #2. 2. Review of the 2/2/11 annual MDS assessment for resident #107 revealed the area of nutritional status triggered, requiring a comprehensive assessment. Review of the 1/20/11 CAA for nutrition revealed it had been completed by CDM #2 instead of the RD.	F 272	**F272 continued** Resident # 21 • Registered Dietitian complete current nutrition assessment with collaboration from CDM and signs CAA 06/01/11 All residents have the potential for nutrition assessment trigger for CAA and need for Registered Dietitian assessment Systemic Process • All CAAS will be completed by Registered Dietitian with certified dietary manager collaboration • All CAAS will be signed by Registered Dietitian • Review and revise policy related to Nutrition Assessments Outcome: 100% of Nutrition Assessments will be completed by a Registered Dietitian Registered Dietitian or designee will evaluate 10 charts per week for completion of CAAS Data and evaluation will be reported monthly to the QA meeting, with discrepancies investigated and resolved.	

6/13/11

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F 272	Continued From page 2 3. Review of the 12/21/10 significant change MDS assessment for resident #17 showed nutritional status triggered, which required a comprehensive assessment. Review of the 12/9/10 CAA for nutrition revealed it had been completed by CDM #2 instead of the RD. 4. Review of the 3/9/11 quarterly MDS assessment for resident #78 showed s/he needed further assessment in the area of nutrition. Review of corresponding CAA revealed the assessment was completed by CDM #2. 5. Review of the 3/11/11 admission MDS assessment for resident #21 showed s/he needed further assessment in the area of nutrition. Review of the 3/20/11 CAA revealed the assessment was signed by CDM #2. 6. During an interview with the MDS coordinator on 5/12/11 at 8 AM, she confirmed that a CDM completed most CAAs for nutrition. According to the 2008 Standards of Practice for Registered Dietitians in Nutrition Care, published by the American Dietetic Association, Standard 1: Nutrition Assessment, The registered dietitian (RD) uses accurate and relevant data and information to identify nutrition-related problems. Rationale: Nutrition Assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals...for nutrition risk factors...It provides the foundation for Nutrition	F 272		

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F 272	Continued From page 3 Diagnosis, the second step of the Nutrition Care Process. Further, the 2008 Standards of Practice specifically state:" "The RD does not delegate the nutrition care process, but may assign certain tasks for the purpose of providing the RD with needed information (e.g., screens, gathering of data and other information) or communicating with and educating patients."	F 272	**F 279 Comprehensive Care Planning/Individualized care planning** Pioneer Manor will ensure the facility must use the results of the assessment to develop, review and revise the residents comprehensive plan of care, includes measurable objectives and timetables to meet a residents medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. This will be accomplished by: (3, #17, #21, #32, #48, #78, #102, #107) Resident #102 Resident discharged 05/26/11 Resident #21 • Care plan based on appropriate assessment regarding pain, individualized and acceptable pain level for the resident documented. Measurable objectives documented on care plan demonstrating pain interventions and resident response.06/01/11 Resident #17 • Care plan based on appropriate assessment regarding pain, individualized and acceptable pain level for the resident documented. Measurable objectives documented on careplan demonstrating pain interventions and resident response. 06/01/11 • Care plan section on resident preferences for pain relief completed 06/01/11	06/26/11
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, medical record review, and review of facility policies, the facility failed to ensure an individualized care plan	F 279		

6/10/11

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F 279	Continued From page 4 was developed in a variety of areas for 8 of 19 sample residents (#3, #17, #21, #32, #48, #78, #102, #107). The findings were: In regard to pain: 1. Review of the medical record for resident #102 showed s/he had diagnoses including fracture of two ribs from a recent fall on 5/2/11. Interview with the resident on 5/9/11 at 4:05 PM revealed the fractured ribs were very painful. Review of the care plan for pain showed it was not individualized to target the specific area of pain in the ribs, there were no measurable goals, and the care plan did not include resident preferences regarding pain management. Interview with the two unit managers on 5/12/11 at 9:15 AM revealed care plans should be individualized. 2. Review of the care plan dated 3/27/11 for resident #21 showed s/he complained of pain daily or almost daily related to incisional and phantom pain. The goal was for pain to be reduced to an acceptable level to allow participation in therapies and activities of daily living (ADLs). The approaches were as follows: assist with repositioning as needed, offer applications of heat and/or cold as needed, medication as ordered by physician and offer as needed (PRN) medication prior to therapy sessions. The care plan was not individualized related to "acceptable" pain level for the resident and lacked measurable objectives for pain control during rest and activity. 3. Review of the April and May 2011 pain flow sheets for resident #17 showed s/he experienced pain and received Vicodin (narcotic pain medication) 5/500 milligrams 64 times for back,	F 279	**F 279 continued** Resident #48 • Assessment and care plan specific to resident feelings of depression and inadequacy documented. Measurable objective and goals individualized to resident.06/01/11 Resident # 107 • CAAS to reflect assessments and OPC meeting results • Pharmacy review of medications completed, Assessment of depression completed 06/01/11 • Behavior tracking documentation revised 06/03/11 Resident #3 • Assessment and care plan specific to resident feelings of depression and inadequacy documented. Measurable objective and goals individualized to resident. Assessment and care planning regarding antidepressive medication and behavior tracking documentation initiated 06/1/11 Resident #78 • Assessment and care plan specific to resident nutrition documented. Measurable objective and goals individualized to resident. Assessment and care planning regarding food intake 06/01/11	

6/13/11

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F 279	Continued From page 5 leg, coccyx or generalized pain in April 2011 and 22 times from 5/1/11 through 5/12/11. Review of the care plan for pain showed interventions were "alternative approach to pain relief, pain medications as ordered, eliminate precipitating factors (no precipitating factors were identified) and educate the resident on pain management. The care plan was not individualized, there were no measurable goals, and the care plan did not include resident preferences regarding pain management. Interview with the two unit managers on 5/12/11 at 9:15 AM revealed care plans should be individualized. 4. Review of the facility's policy and procedure on pain management, dated 1/31/11, documented "....pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented. For example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. Pain management interventions shall reflect the sources, type and severity of pain...." In regard to psychological issues: 1. Review of the significant change MDS assessment dated 4/21/11 for resident #48 showed s/he triggered for mood state requiring additional assessment. Review of the CAA for mood stated showed the resident was depressed and "reported that he doesn't feel like [s/he] is up to standard." Review of the 4/19/11 care plan revealed the resident's feelings of inadequacy and depression were not addressed. The care plan showed a problem area of "coping/grief" with	F 279	**F 279 continued** Resident # 32 • Assessment and care plan specific to oxygen usage documented. Measurable objective and goals individualized to resident. Assessment and care planning regarding parameters and monitoring of oxygen initiated. Physician order obtained for oxygen monitoring and parameters. 05/13/11 **Other residents** • CAAS to reflect assessments and OPC meeting results • Review all residents on oxygen to verify orders reflect monitoring parameters, obtain order and update care plans as appropriate • Review residents for pain assessment, interventions, preferences, tolerable pain goal and reassessment documentation Systemic processes • Computer based care planning education to be completed • Evaluate MDS assessments to ensure completion to develop care plan • CAAS to reflect assessments and OPC meeting results • Evaluate targeted care plans at Risk meeting weekly	

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F 279	Continued From page 6 a generic goal of "resident will exhibit positive coping mechanisms." The interventions that were identified were not resident specific, they were to "encourage expression of grief/concerns" and to "set realistic goals in conjunction with resident." The interventions lacked any specific significance to the resident's needs. 2. Review of physician's orders for resident #107 showed Nortriptyline (tricyclic anti-depressant) 10 mg was ordered on 10/22/10. Review of the 2/2/11 annual MDS assessment showed the resident appeared down, depressed, or hopeless nearly every day. Review of section V of this assessment showed the resident triggered for comprehensive review of psychotropic drug use. Review of the CAA (comprehensive assessment) showed psychotropic drug use should be addressed in the resident's care plan. However, review of the 5/3/11 care plan showed psychotropic drug use had not been addressed. Interview with the two unit managers on 5/12/11 at 9:15 AM revealed they were unsure why psychotropic drug use was not addressed in the care plan because it should have been. 3. Review of the care plan dated 3/22/11 for resident #3 for alteration in thought process and mood showed goals included carrying out " normal routine " and make decisions with cueing and reminders. Approaches to meet the goals included medications as ordered, explain procedures, cueing and reminders as needed. The care plan was not individualized with measurable, resident-specific outcomes for mood and decision-making. Further, the care plan did not address specifics concerning the resident ' s	F 279	**F 279 continued** • Review and revision as appropriate of oxygen protocol consistent with organization use • Develop process for meal intake records for high risk residents • Initiate behavior tracking sheets when mood/function or change in behavior noted • Staff education regarding assessment, intervention, evaluation and documentation of the following o Pain, Meal intake, Oxygen, depression, mood, Antipsychotic medications to include risk/benefit, Physician communication and documentation of orders, and medication reconciliation and individualization of care plans Outcome: 95% of care plans will reflect accurate assessment Nurse managers or designee 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.	

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F 279	Continued From page 7 anti-depressive medication. In regard to nutrition: Review of the care plan dated 4/1/11 for resident #78 showed s/he had alteration in nutrition related to a history of poor food intake. The goal was s/he would continue to take oral nutrition and the approaches were as follows; weigh monthly, high calorie/high protein diet, 4 ounces Resource or Mighty Shake at meals. Offer snacks between meals, monitor, encourage meals. The care plan did not include measurable objectives for food intake and was not individualized to the resident's food preferences. In regard to oxygen therapy: Review of the care plan dated 4/1/11 for resident #32 showed s/he had impaired gas exchange due to obesity, side effects of narcotics, and anxiety medications. The goal was for the resident to maintain oxygenation for comfort level. The approach was as follows: "Oxygen as ordered. Usually just uses in bed." The care plan was not specific for monitoring and lacked resident-specific, measurable objectives for oxygenation.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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	F 280	**F 280 Care Planning** Pioneer Manor will ensure the resident has the right, unless adjudged incompetent or otherwise found incapacitated under the laws of the State to participate in planning care and treatment or changes in care and treatment. This will be accomplished by: Resident #107 • Care plan updated to reflect finger foods at noon as part of the nutritional care plan June 1, 2011 Resident #78 • Care plan updated to reflect ambulation June 1, 2011 • CAAS to reflect assessments and OPC meeting results	06/26/11

6/13/11

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F 280	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the care plan was updated to reflect the current needs for 2 of 19 sample residents (#78, #107). The findings were: 1. Review of the 2/2/11 CAA for resident #107 showed s/he was to receive a meal of finger foods at noon. Review of the care plan, however, showed the use of finger foods was not included as part of the intervention for nutrition. Interview with the two unit managers on 5/12/11 at 9:15 AM revealed finger foods should have been included on the care plan as part of the nutritional care plan interventions. 2. Random observations on 5/9/11 of resident #78 showed s/he was in a wheelchair and did not walk. Review of the 3/9/11 quarterly MDS showed the resident did not walk at any time in his/her room or corridor during the 7-day observation period. His/her care plan showed the resident "...used a walker with assist for short distances." Interview with LPN #1 on 5/12/11 at 8:30 AM	F 280	**F280 continued** Systemic processes • Staff education regarding care plan documentation, individualization, assessment and intervention via computerized education program and individualized education. • Evaluate MDS assessments to ensure completion to develop care plan • CAAS to reflect assessments and OPC meeting results • Evaluate targeted care plans at Risk meeting weekly Outcome: 95% of care plans will reflect accurate assessment Nurse managers or designee 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.	

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F 280	Continued From page 9 verified the resident was not able to walk.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to follow professional standards for 1 sample resident (#71) regarding a required change of the resident's PICC line dressing. In addition, the facility failed to follow professional standards regarding oxygen administration for 1 of 6 sample residents (#71) who required oxygen. The findings were: 1. Refer to F328 regarding the facility's failure to change a required PICC line dressing for resident #71. 2. Refer to F328 regarding the facility's failure to obtain a physician's order for resident #71's oxygen prior to administration, and subsequent failure to follow the actual physician's order for oxygen administration when obtained.	F 281	**F 281 Services provided meet professional standards** Pioneer Manor will ensure the services provided or arranged by the facility must meet professional standards of quality. This will be accomplished by: (#71) Resident # 71 Resident discharged to CCMH 05/15/11 • Update care plan to reflect current resident status May 1, 2011 • Change PICC dressing and place on treatment sheet for consistent compliance with policy May 10, 2011 • Update care plan to reflect oxygen usage 05/10/11 • Clarify order and parameters for monitoring oxygen with physician 05/10/11 All residents have the potential to be affected by inaccurate physician orders. Any orders recoghized as inconsistent with resident current condition to be clarified and care plan updated. MDS assessment and OPC team to verify and clarify any inconsistent or inaccurate orders during care planning process. • Review all residents on oxygen and IV therapy for consistent compliance with policy. Clarify and update any care plans or orders that are inconsistent with policy.	06/26/11
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.	F 282		

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F 280	Continued From page 9 verified the resident was not able to walk.	F 280	**F 281 continued** Systemic processes • Develop process to validate current information for physician • CAAS to reflect assessments and OPC meeting results • Staff education regarding assessment, intervention, evaluation and documentation of the following o Physician communication and documentation of orders o Oxygen protocol o IV flush and dressing protocol • Review and revise oxygen protocol Outcome: 100% of special services will have physician order. 100% of special services will have care per policy Nurse Managers or designee to audit 10 charts per week. Data will be collected, evaluated and reported at monthly QA meeting with discrepancies evaluated and investigated	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to follow professional standards for 1 sample resident (#71) regarding a required change of the resident's PICC line dressing. In addition, the facility failed to follow professional standards regarding oxygen administration for 1 of 6 sample residents (#71) who required oxygen. The findings were: 1. Refer to F328 regarding the facility's failure to change a required PICC line dressing for resident #71. 2. Refer to F328 regarding the facility's failure to obtain a physician's order for resident #71's oxygen prior to administration, and subsequent failure to follow the actual physician's order for oxygen administration when obtained.	F 281		
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.	F 282		

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PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to follow the plan of care for 1 of 19 sample residents (#48). The findings were: Review of the 4/19/11 care plan showed resident #48 had interventions developed to address pain and associated behaviors. Refer to citation F309 for details on the facility's failure to follow the planned interventions for this resident's pain.	F 282		
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 observation, medical record review, and staff and resident interview, the facility failed to ensure 2 of 10 sample residents (#21, #48) identified by the facility as having pain, had an effective pain management program. Due to the facility's failure in developing and implementing a pain management program, resident #48 experienced avoidable pain during staff assisted transfers. The findings were: In regard to pain concerns:	F 309	**F 282 Services provided by qualified person per care plan** Pioneer Manor will ensure 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 will be accomplished by: (# 48) **Pain and Depression:** Resident #48 Daily skilled nursing notes 04/08/11 - 04/27/11 demonstrate pain assessment. Resident stated no pain. On readmit on 04/8/11 pain assessment completed Resident stated no pain • Care plan based on appropriate assessment regarding pain, individualized and acceptable pain level for the resident documented. Measurable objectives documented on care plan demonstrating pain interventions and resident response. • Psychologist recommendations part of care plan • Individual resident preferences incorporated into care plan • Clarification of resident home medications and appropriate orders obtained 05/17/11 • Resident education documented regarding pain management plan • Review admit/readmit orders 06/3/11	06/26/11

6/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to follow the plan of care for 1 of 19 sample residents (#48). The findings were: Review of the 4/19/11 care plan showed resident #48 had interventions developed to address pain and associated behaviors. Refer to citation F309 for details on the facility's failure to follow the planned interventions for this resident's pain.	F 282	**F282 continued** Resident #48 • Medication reconciliation of all home medications review and orders clarified regarding antidepressant medications 06/2/11 • Behavior tracking sheet documentation reviewed and care plan updated to reflect current assessment 06/01/11 Other residents: • CAAS to reflect assessments and OPC meeting results	
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 observation, medical record review, and staff and resident interview, the facility failed to ensure 2 of 10 sample residents (#21, #48) identified by the facility as having pain, had an effective pain management program. Due to the facility's failure in developing and implementing a pain management program, resident #48 experienced avoidable pain during staff assisted transfers. The findings were: In regard to pain concerns:	F 309	• Review residents for behavior monitoring, signs and symptoms of depression, refer for consultations as appropriate • Review residents for pain assessment, interventions, preferences, tolerable pain goal and reassessment documentation <u>Systemic Processes</u> • Computer based care planning education • Evaluate MDS assessments to ensure completion to develop care plan • Develop process for medication reconciliation verification • CAAS to reflect assessments and OPC meeting results	

6/13/11

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F 282	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to follow the plan of care for 1 of 19 sample residents (#48). The findings were: Review of the 4/19/11 care plan showed resident #48 had interventions developed to address pain and associated behaviors. Refer to citation F309 for details on the facility's failure to follow the planned interventions for this resident's pain.	F 282	**F 282 continued** • Evaluate targeted care plans at Risk meeting weekly • Develop process for notification of appropriate departments for medication changes or behavior changes • Staff education regarding assessment, intervention, evaluation and documentation of the following: Pain, Depression, Mood, Antipsychotic medications to include risk/benefit, Physician communication and documentation of orders, and medication reconciliation and individualization of care plans Outcome: 95% of care plans will reflect accurate assessment Nurse managers or designee to audit 10 charts per week for assessments and care planning to reflect assessments utilizing audit tool and MDS triggers. Evaluation: Findings will be reported monthly to the QA meeting, with discrepancies investigated and resolved.	
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 observation, medical record review, and staff and resident interview, the facility failed to ensure 2 of 10 sample residents (#21, #48) identified by the facility as having pain, had an effective pain management program. Due to the facility's failure in developing and implementing a pain management program, resident #48 experienced avoidable pain during staff assisted transfers. The findings were: In regard to pain concerns:	F 309	**F 309 Provide Care and Service for Highest Well Being** Pioneer manor will ensure 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 will be accomplished by: (# 21, # 48)	06/26/11

6/13/11

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F 309	Continued From page 11 1. Review of the admission MDS assessment completed on 1/24/11 showed resident #48 had active diagnoses of hypertension, gastroesophageal reflux disease, renal failure, pneumonia, dementia, and vision problems. Review of the psychologist's consultation dated 3/9/11 showed the resident exhibited behavioral problems including aggression during care. Further review of the consultation showed "...back pain should be targeted as a potential variable related to physical aggression." The evaluation showed that "Chart review and resident assessment reveal that [the resident] has a history of back injury and surgery...[the resident] reports that medication helps pain intensity somewhat and that, at home, [s/he] used heat and pressure to help manage [his/her] low back pain." Continued review of the consultation showed the psychologist made detailed recommendations that were discussed with the interdisciplinary team. These recommendations were to train staff to assess pain prior to transfer using a simple pain rating scale or a simple yes/no pain question. In addition, she recommended the charge nurse be familiar with the resident's problems with pain, and to "consult with family members, review the chart, and discuss the issue with [the] resident so that everyone was on the same page about [his/her] potential for significant pain." The recommendations also included the need for staff to be trained regarding non-medicinal options for pain control. Finally a recommendation to, "...consider requesting re-evaluation of current pain management medication for optimum effectiveness..." Review of the resident's medical record	F 309	**F309 continued** **Pain:** Resident #21 • Care plan based on appropriate assessment regarding pain, individualized and acceptable pain level for the resident documented. Measurable objectives documented on care plan demonstrating pain interventions and resident response. 06/01/11 • Communication with physician regarding resident frequent use of pain medication and order obtained for scheduled pain medication 05/13/11 • Staff education regarding need for reassessment of pain and interventions effectiveness • Resident education documented regarding pain management plan 06/01/11 Resident #48 • Care plan based on appropriate assessment regarding pain, individualized and acceptable pain level for the resident documented. Measurable objectives documented on care plan demonstrating pain interventions and resident response. 06/01/11	

6/13

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F 309	Continued From page 12 showed there was no nursing pain assessment completed to show the resident's pain frequency, tolerable limits, or to further develop the recommendations made by the psychologist. However, review of the 4/19/11 care plan showed pain was a problem area. The care plan interventions for pain showed staff were to provide pain medication as ordered, and alternative approaches to medication such as rest, warm blanket and diversionary activity. The last intervention was to monitor for signs of pain including changes in behavior and grimacing. The care plan also showed behaviors were identified as a problem and pain was shown as a contributing factor. The care plan referred to an attached sheet, a behavior plan developed by the psychologist. Review of this "Behavioral Prescription" showed it was developed from the above mentioned 3/9/11 psychology consultation. Two specific behaviors were identified: Offensive sexual conduct, and physical aggression toward nursing staff during transfers. The interventions for the physical aggression toward staff during transfers were to assess the resident's level of pain prior to transfer, consultation with therapy to determine the best transfer techniques, and for the charge nurse to provide pain management. Prior to the recent hospitalization and subsequent re-admission, the March 2011 MAR showed the resident had an order for routine Tylenol 500 mg every 6 hours while awake. Review of the April 2011 MAR showed the resident went to the hospital on 4/4/11 due to pneumonia. According to the 4/8/11 notification to the physician, the nurse wrote, "Resident was re-admitted...enclosed are the following orders. Do you agree?" The physician documented agreement. However, review of these 4/8/11	F 309	**F309 continued** • Psychologist recommendations part of care plan • Individual resident preferences incorporated into care plan 06/01/11 • Clarification of resident home medications and appropriate orders obtained • Resident education documented regarding pain management plan **Depression:** Resident #48 • Medication reconciliation of all home medications review and orders clarified regarding antidepressant medications 05/27/11 • Behavior tracking sheet documentation reviewed and care plan updated to reflect current assessment 06/02/11 • Social worker notification and updating of care plan regarding mood/behavior 05/12/11	

6/13/11

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F 309	Continued From page 13 admission orders showed they did not include the routine Tylenol or any other PRN (as needed) pain medications. Interview with RN #3 on 5/12/11 at 10:35 AM revealed they (nursing staff) were instructed not to question re-admission orders. The nurse then verified a new pain assessment was not completed when the resident returned from the hospital without the pain medication. The following concerns were identified: a. Review of the April 2011 behavior tracking form showed there were 26 episodes when the resident was involved in "hitting." Review of the behavior tracking form for May 2011 showed one episode on 5/2/11 of the resident "hitting other residents." Although the evaluation identified physical aggression as a possible reaction to pain, review of the April and May 2011 pain flow sheets showed they were blank, at no time during the months had the possibility of pain been assessed. b. Observation on 5/12/11 at 11:05 AM showed CNAs #4 and #5 transferred resident #48 from the wheelchair to a dining room chair. The aides failed to ask the resident about any pain prior to the transfer. The resident was able to participate in the transfer with some weight bearing. However, the resident did not want to move as fast as the aides planned. The aides wanted the resident to get up on the count of three. The resident delayed this count and eventually got up from the wheelchair with some moaning. c. Interview with CNA #5 on 5/12/11 at 10:07 AM revealed she was familiar with the resident and had transferred him/her many times. The CNA stated most of the time the resident said, "ouch, ouch, ouch" when s/he was touched,	F 309	**F309 continued** Resident #3 • Behavior tracking sheet documentation reviewed and care plan updated to reflect current assessment 06/01/11 • Social worker notification and updating of care plan regarding mood/behavior05/12/11 Other residents: • CAAS to reflect assessments and OPC meeting results • Review residents for behavior monitoring, signs and symptoms of depression, refer for consultations as appropriate • Review residents for pain assessment, interventions, preferences, tolerable pain goal and reassessment documentation Systemic processes: • Computer based care planning education • Pain protocol review and revision • Evaluate MDS assessments to ensure completion to develop care plan • Develop process for medication reconciliation verification	

6/13/11

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F 309	Continued From page 14 repositioned or transferred. The CNA did not think the resident received any pain medication. d. Interview with CNA #6 on 5/12/11 at 10:30 AM revealed she was aware the resident had back pain. The CNA stated the resident would say that his/her back hurt when moved. The CNA also revealed "most of the time" the resident would "hit, bite and pinch" when s/he was transferred or moved. The CNA stated the nurse was notified when these things happened, but was unsure if the resident received any pain medication. e. Interview with the resident on 5/12/11 at 9:45 AM revealed s/he had pain in the lower back. The resident was unable to describe the intensity of the pain, but stated the pain was worsened with movement. The resident further revealed s/he did not receive any pain medications. The resident stated "It would be nice." The resident then stated that s/he had "gotten used to it" when asked about his/her back pain. f. Interview with a performance improvement staff member and LPN #2 on 5/12/11 at 9:48 AM verified the resident needed to be monitored for pain according to the care plan, but acknowledged there was no documentation to show this was happening. In addition, there were no orders for pain medication if the resident should need them, and nothing to show that any non-medicinal approaches were being used to relieve the resident's back pain. 2. Medical record review for resident #21 showed a 3/17/11 order for a Fentanyl patch (a pain medication) 75 micrograms per hour to be changed every 3 days. In addition, there was a 3/17/11 order for hydrocodone/apap 10/500	F 309	**F309 continued** • CAAS to reflect assessments and OPC meeting results • Evaluate targeted care plans at Risk meeting weekly • Develop process for notification of appropriate departments for medication changes or behavior changes • Staff education regarding assessment, intervention, evaluation and documentation of the following o Pain, Depression, Mood, Antipsychotic medications to include risk/benefit, Physician communication and documentation of orders, and medication reconciliation and individualization of care plans Outcome: 95% of care plans will reflect accurate assessment Nurse managers or designee 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.	

6/13/11

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F 309	Continued From page 15 milligram tablet to be given every four hours as needed for pain. The following concerns were identified with monitoring the effectiveness of the pain medication: a. Review of the pain flow sheets for April and May 2011 showed the resident received the PRN pain medication 128 times in April, and 43 times in May from 5/1-5/11. Most times, the pain flow sheets showed the resident rated his/her pain at a 6 on a scale of 1-10 prior to the medication being administered. Of the 106 times when the effectiveness of the pain medication was re-evaluated, the flow sheets showed some relief with pain levels reduced to a 3-4 on a 1-10 scale. However, this left 65 times in which there was no re-assessment completed to show if the medication was effective in reducing the resident's pain. b. Review of the medical record failed to show a pain assessment that identified the resident's acceptable level of pain c. Interview on 5/10/11 at 1 PM with the resident revealed s/he felt the pain medication was somewhat effective. Interview with LPN #1 on 5/11/11 at 2:40 PM revealed the frequent use of the PRN pain medication had not been communicated to the physician. Based on medical record review and staff and resident interview, the facility failed to effectively assess, care plan, and treat depression for 2 of 10 sample residents (#3, #48) who were identified as having symptoms of depression. The findings were: 1. Review of the medical record showed resident #48 was admitted to the facility on 1/11/11. At that time the resident did not have any diagnosis of	F 309		

6/1/11

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F 309	Continued From page 16 depression. However, review of the 1/24/11 admission MDS assessment showed the resident had multiple symptoms of depression nearly everyday. Review of the CAA narrative notes for mood state, dated 1/24/11, showed the resident had indicators of depression including thoughts of being "better off dead" or of hurting him-/herself in some way." The CAA further showed the resident would be monitored closely, and the physician would be notified. In addition, a referral would be made to a psychologist for evaluation. Review of the medication orders showed the resident was started on amitriptyline (an anti-depressant) on 1/31/11. Review of the April 2011 MAR showed the resident was sent to the hospital on 4/3/11 and the anti-depressant medication was discontinued on 4/4/11. Review of the 4/8/11 re-admission orders showed they did not include an antidepressant. The following concerns related to depression were identified: a. Review of the psychologist's evaluation dated 3/9/11 showed a recommendation to "Monitor for increased signs/symptoms of depressed mood, increased irritability/agitation, becoming more socially withdrawn..., and statements about death or dying, feeling helpless, worthless, etc. Re-refer if necessary." Review of the behavior monitoring sheets for March, April, and May 2011 failed to show signs and symptoms of depression were being monitored. b. Review of the 4/25/11 significant change MDS assessment showed the resident triggered for mood state. The CAA narrative notes dated 4/25/11 related to mood showed the resident continued to have feelings of depression, and "...doesn't feel like [s/he] is up to standard." There was no discussion of any anti-depressant medication at that time. Review of the medical	F 309		

6/15/11

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F 309	Continued From page 17 record failed to show any additional assessment related to the residents depression or the acknowledgment that the medication was discontinued and possibly still needed. c. Review of the 4/19/11 care plan revealed it failed to address the resident's depression. d. Review of the April and May 2011 MARs showed the resident was not receiving any medication to treat depression. Interview with RN #3 on 5/12/11 at 10:35 AM verified the antidepressant was not re-ordered when the resident returned from the hospital, and she was told the facility policy was not to question re-admission medication orders. At that time, the RN stated the resident had benefited from the medication when it was in use. e. Interview with the resident on 5/9/11 at 5:30 PM revealed feelings of "not fitting in." Interview with the social worker on 5/12/11 at 8:40 AM revealed she was aware of the resident's behaviors and signs and symptoms of depression. She stated the resident was recently moved from another neighborhood and was still adjusting to this change. The move to a different neighborhood occurred a few days prior to the hospital admission. She was not aware of the discontinued medication or the lack of monitoring for signs of depression. 2. Review of the history and physical dated 2/23/11 for resident #3 showed s/he had a history of depression and took Zoloft (anti-depressant) 50 mg daily. Review of the medical record showed a faxed request dated 3/2/11 from the nursing staff to the resident's physician for an increase in the Zoloft to 75 mg for increased depression. Further review of the medical record showed a communication written on 4/28/11	F 309		

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F 309	Continued From page 18 stated the resident showed another increase in depression, was sleeping more, and not eating well. The following concerns were identified: a. Review of the "Behavior/Intervention Monthly Flow Record" for March, April, and May 2011 revealed no evidence depressive behaviors were assessed or monitored. Review of the nursing notes by a performance improvement staff member on 5/12/11 at 9:45 AM revealed no evidence the resident was assessed for signs and symptoms of depression. b. Interview with social service worker #1 on 5/12/11 at 9:45 AM revealed she was not aware of the most recent increase in this resident's depression. c. Review of the current care plan showed depression was not addressed except for "medications as needed."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide adequate incontinence care for 1 of 3 sample residents (#78) who required such assistance. The findings were: Observation of resident #78 on 5/9/11 at 4:45 PM showed CNA #1 failed to cleanse the resident's	F 312	**F 312 ADL care provided for dependent residents** Pioneer Manor will ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by: #78 • Coaching counseling of CNA #1 regarding pericare expectations and policy 06/02/11 • Review and update care plan for resident to reflect pericare and toileting hygiene 06/2/11 • All incontinent residents have the potential for skin breakdown related to excoriating fluids on perineum Systemic processes • Staff education/competency on pericare and incontinence care • Development of annual skill stations related to personal hygiene and ADL Outcome measure: 100% incontinent residents will have appropriate pericare Nursing will monitor 30 observations per month Report monthly to QA committee. Immediate education and intervention will occur for all discrepancies	06/26/11

6/13/11

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F 312	Continued From page 19 anterior perineum after s/he was found to be incontinent of urine. Medical record review of the 3/9/11 quarterly MDS revealed the resident required extensive assistance with toilet use and personal hygiene. Interview with LPN #2 on 5/11/11 at 1:20 PM revealed all areas of the skin that have come in contact with urine was to be cleansed.	F 312	**F 323 Accidents and Supervision/Fire extinguisher case and fans** Pioneer Manor will ensure resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: **Safe environment**	06/26/11
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to identify and correct potential accident hazards on 1 of 4 resident units. The findings were: 1. A wall-mounted fire extinguisher cabinet was observed while touring the secure unit on 5/9/11. The metal cabinet had exposed corners with rough metal creases along the bottom. Donning examination gloves and running a hand across the lower corners caused the glove material to snag and tear against the rough surfaces. 2. Observation in the secure unit on 5/10/11 at 5:10 PM showed three fans placed on the floor in the hallway leading from the dining room to	F 323	• Wall mounted fire extinguisher o Bottom edge smoothed to prevent accidental injury May 12, 2011 • Resident #99, RN #1 and CNA # 2 o Fans moved back to original position, immediate staff education regarding need to keep environment consistent to prevent accidental injury especially in memory support unit May 12, 2011 • All residents have the potential for accidental injury due to unfamiliar environment or hazards in the environment o Safety coach to do environmental tours to identify risks in environment. Any issues will be identified and work orders completed. Systemic processes • Care plans to reflect interventions regarding environmental safety as appropriate to assessment of resident • Review activity and restorative program to enhance fall prevention and safety and provide structure	

6/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 05/12/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 resident rooms. The fans were positioned against the walls of the hallway with the electrical cords secured behind the wall-mounted hand rail. Non-sample resident #99 left the dining room at 5:25 PM and walked to his room; the resident walked with a cane and further steadied his/her gait by leaning against the wall and handrail with his/her right shoulder and arm. On two occasions the resident altered his/her course to avoid these floor fans and was observed to shuffle around the fans with a hesitant, unsteady gait. Interview with RN #1 on 5/12/11 at 10:37 AM confirmed floor fans were used to augment ventilation in the secure unit. She acknowledged residents might find the fans to be an obstacle, particularly residents who ambulated with the aide of a cane or walker. A second staff interview with CNA #2 reiterated that floor fans were frequently used in the secure unit to help ventilation.	F 323	**F 323 continued** • General Safety Coach Education 06/02/11 • Exchange current fans for tall slender column fans to minimize potential for injury and tripping, 06/01/11 Outcome measure: Pioneer Manor will have safe environment for residents and staff. Safety coaches will monitor environment for safety hazards and complete monthly checklist Data will be reviewed in the monthly Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly	06/26/11
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 328	**F 328 Treatment/Care for special needs** Pioneer Manor will ensure residents receive proper treatment and care for the following special services: Injections, parenteral and enteral fluids colostomy, ureterostomy or ileostomy care, trach care, trach suctioning, respiratory care, foot care and prostheses (#71) Resident # 71 Discharge to CCMH 05/15/11 • Update care plan to reflect current resident status May 12, 2011 • Change PICC dressing and place on treatment sheet for consistent compliance with policy May 12, 2011 • Place PICC protocol on resident chart May 12, 2011 • Update care plan to reflect oxygen usage	

6/13/11

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F 328	Continued From page 21 staff interview, and review of policies and procedures, the facility failed to change a PICC line dressing for 1 of 1 sample resident (#71) who had a PICC (peripherally inserted central catheter) line. In addition, the facility failed to obtain, clarify, and follow physician's orders regarding oxygen administration for 1 of 6 sample residents (#71) who required oxygen. The findings were: The following concerns were noted regarding the PICC line for resident #71: Review of the medical record for resident #71 showed s/he had diagnoses that included bacterial endocarditis and coronary artery disease. The review showed the resident had a PICC that had been in his/her right upper arm that had been placed during a recent hospital stay. The PICC line was used to administer intravenous antibiotics. Observation on 5/10/11 at 10:20 AM showed the PICC line dressing was dated as last being changed 24 days earlier (4/16/11). The surveyor notified RN #3 of the date on the dressing and she immediately changed it. During an interview with RN #3 immediately after the dressing change, she stated the dressing should be changed every seven days in accordance with the facility's policy. According to the policy titled, "Central Venous Catheter Dressing Changes," revised October 2010, staff should "Change transparent semi-permeable membrane (TSM) dressings at least every 7 days and PRN (when wet, soiled, or not intact)." According to Elkin, Perry, and Potter in "Nursing	F 328	**F328 continued** • Clarify order and parameters for monitoring oxygen with physician 05/10/11 All residents have the potential to be affected by inaccurate physician orders. Any orders recognized as inconsistent with resident current condition to be clarified and care plan updated. MDS assessment and OPC team to verify and clarify any inconsistent or inaccurate orders during care planning process. Review all residents on oxygen and IV therapy for consistent compliance with policy. Clarify and update any care plans or orders that are inconsistent with policy. Systemic processes • Develop process to validate current information for physician • CAAS to reflect assessments and OPC meeting results • Staff education regarding assessment, intervention, evaluation and documentation of the following o Physician communication and documentation of orders o Oxygen protocol o IV flush and dressing protocol • Review and revise oxygen protocol	

6/2/11

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F 328	Continued From page 22 Interventions & Clinical Skills," 4th Edition 2007: "Provide insertion site care every .....7 days and PRN for transparent dressings." The following concerns regarding oxygen administration for resident #71 was noted: Review of the medical record for resident #71 showed s/he had diagnoses which included chronic obstructive pulmonary disease and coronary artery disease. Observation on 5/10/11 from 8:30 AM through 9:15 AM (45 minutes) showed the resident was in bed, and there was oxygen via nasal cannula running at 2 liters per minute. However, the oxygen tubing was noted to be beside the resident in bed and not being used by the resident. In addition to the oxygen not being used, review of the medical record showed there were actually no orders for the use of oxygen for this resident. During an interview with RN #3 on 5/10/11 immediately after the observation, she stated the resident used oxygen continuously. The RN then verified there was not an order in the medical record and proceeded to request one. Review of this order showed the resident was to receive continuous oxygen via nasal cannula at 2 to 4 liters/minute to maintain an oxygen saturation level of 90% or above. Observation on 5/11/11 from 11:35 AM through 12:07 PM (32 minutes) showed the resident did not have oxygen therapy in use. During an interview with RN #4 immediately after this observation, she stated that the resident should have oxygen in use continuously. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th	F 328	**F 328 continued** Outcome: 100% of special services will have physician order. 100% of special services will have care per policy Nurse Managers or designee to audit 10 charts per week Data will be collected, evaluated and reported at monthly QA meeting with discrepancies evaluated and investigated	

6/13/11

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F 328	Continued From page 23 Edition, 2008: "Skill and functions that professional nurses perform in daily practice include: ... Administer treatments per physician's order."	F 328		06/26/11
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unnecessary drugs for 1 of	F 329	**F 329 Unnecessary Drugs/Gradual dose reduction** Pioneer Manor will ensure each resident's drug regimen must be free from unnecessary drugs, 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 contraindicated Resident #5 • Revision and Review of behavior tracking 06/03/11 • Psychiatry appt 06/08/11 All residents on antipsychotic medications have potential for dose reduction programs Systemic processes • All assessment findings will be added to care plan and will be reviewed at QPC meetings	

6/13/11

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F 329	Continued From page 24 19 sample residents (#5). The findings were: Review of the medical record for resident #5 showed s/he had diagnoses which included depression and psychosis. Review of the April 2011 recapitulation of physician's orders showed the resident had medication orders for the following: a 2/22/10 order for paroxetine (anti-depressant and selective serotonin reuptake inhibitor) 20 mg by mouth daily, a 4/28/10 order for duloxetine (anti-depressant and serotonin/norepinephrine reuptake inhibitor) 60 mg by mouth daily, and a 6/30/10 order for quetiapine (anti-psychotic) 30 mg by mouth twice daily. Review of the monthly consultant pharmacist medication regimen review and physician notification showed a 10/14/10 recommendation by the pharmacist to continue the duloxetine and discontinue the paroxetine by a tapering schedule so that the resident's serotonin load could be further reduced. The medical record also showed the facility failed to receive a response to the recommendation, and failed to obtain an explanation as to why both serotonin reuptake inhibitor medications were continued as originally ordered. Further review of the medical record showed the facility failed to attempt a gradual dose reduction of the quetiapine, or obtain an explanation for continuing the medication as ordered. During an interview with the facility's two unit managers on 5/10/11 at 5 PM, both managers stated that no gradual dose reductions had been attempted for any of the three medications, and no explanations were given for not following the 10/14/10 pharmacist recommendations. According to Lexi-Comp's Drug Reference	F 329	**F 329 continued** • Consultant Pharmacist Medication Regimen Review and Physician Notification forms will be completed by Pharmacy monthly and per request. The form will be reviewed by nurse managers. Further assessments will be added by nurse managers as appropriate prior to physician review. Risk/benefit documentation to assist in dose reduction education and with signs of significant change. • Interventions to assist in dose reduction attempts will be reflected in the care plans and will be reviewed at OPC meetings. These forms will be located in the resident chart under the pharmacy section. • Antipsychotic Medication Quarterly/PRN Evaluation/AIMS to be completed on all residents who are taking antipsychotic medications. • Weekly at risk meetings to validate that all interventions are put in place and appropriate referrals are made to include behavioral health. Outcome: 95% assessments will be completed on residents and interventions placed on care plan Nurse Managers or designee to audit 10 charts each week Data will be collected, evaluated and reported at monthly QA meeting with discrepancies evaluated and investigated	

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F 329	Continued From page 25 Handbooks Drug Information Handbook for Nursing 2010, there is a "Potential for severe reaction when [paroxetine] used with ...serotonin norepinephrine reuptake inhibitor: serotonin syndrome (hyperthermia, muscular rigidity, mental status changes/agitation, autonomic instability) may occur."	F 329		06/26/11
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure drug regimen review recommendations were acted upon for 1 of 19 sample residents (#5) who received medications. The findings were: Refer to F329 for details regarding failure of the facility to ensure that a drug regimen review recommendation was acted upon for resident #5.	F 428	**F 428 Drug Regimen review** Pioneer Manor will ensure drug regimen review must be done at least once a month by a licensed pharmacist and must report any irregularities to the attending physician and director of nursing Resident #5 • Revision and Review of behavior tracking 06/03/11 • Psychiatry appt 06/08/11 All residents on antipsychotic medications have potential for dose reduction programs Systemic processes • All assessment findings will be added to care plan and will be reviewed at OPC meetings • Consultant Pharmacist Medication Regimen Review and Physician Notification forms will be completed by Pharmacy monthly and per request. The form will be reviewed by nurse managers. Further assessments will be added by nurse managers as appropriate prior to physician review. Risk/benefit documentation to assist in dose reduction education and with signs of significant change. • Interventions to assist in dose reduction attempts will be reflected in the care plans and will be reviewed at OPC meetings. These forms will be located in the resident chart under the pharmacy section.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 329	Continued From page 25 Handbooks Drug Information Handbook for Nursing 2010, there is a "Potential for severe reaction when [paroxetine] used with ...serotonin norepinephrine reuptake inhibitor; serotonin syndrome (hyperthermia, muscular rigidity, mental status changes/agitation, autonomic instability) may occur.".	F 329	**F 428 continued** • Antipsychotic Medication Quarterly/PRN Evaluation/AIMS to be completed on all residents who are taking antipsychotic medications. • Weekly at risk meetings to validate that all interventions are put in place and appropriate referrals are made to include behavioral health. Outcome: 95% assessments will be completed on residents and interventions placed on care plan Nurse Managers or designee to audit 10 charts each week Data will be collected, evaluated and reported at monthly QA meeting with discrepancies evaluated and investigated	06/26/11
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure drug regimen review recommendations were acted upon for 1 of 19 sample residents (#5) who received medications. The findings were: Refer to F329 for details regarding failure of the facility to ensure that a drug regimen review recommendation was acted upon for resident #5.	F 428	**F 441 Infection Control** Pioneer Manor will ensure an Infection Control program under which it investigates, controls and prevents infections in the facility • CNA #2 o Immediate training and coaching regarding handwashing and storage of used sharps containers May 12, 2011 o Immediate removal of sharps containers from handwashing station May 12, 2011 • All staff / residents have potential to be affected by breach of infection control practices, see measures below.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 26 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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and	F 441	**F 441 continued** Systemic Processes • Infection Control / Safety Education • Revision of safety coach form to include review of handwashing stations for infection control issues/sharps containers • Safety Coach education 06/2/11 Outcome measure: 100% of staff/handwashing stations will adhere to infection control practices Safety coach and charge nurse or designee review of handwashing areas weekly Report monthly to QA committee. Immediate education and intervention will occur for all discrepancies	

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F 441	Continued From page 27 consideration of nationally-recognized infection control guidelines, the facility failed to provide an acceptable hand washing area on 1 of 4 resident units. The findings were: Observation on 5/09/11 at 4:20 PM showed a hand washing area located in a small alcove at the nurses station in the secure unit. The hand washing facility included a sink and wall-mounted soap and paper towel dispensers. Two sharps containers were also observed in the hand washing area; a large container was located immediately adjacent to the sink and directly in front of the soap dispenser, a smaller container was positioned beneath the paper towel dispenser. Sharps containers are hard plastic waste receptacles used for medical items that have a point, sharp edge, or tip that can puncture the skin and potentially create an infection hazard. Both containers in the hand washing area were about 1/3 filled with lancets, needles, blood collection tubes, plastic tubing, and other unidentified waste. Several of these items appeared to have been used to draw blood or collect finger-stick blood samples. On 5/10/11 at 1:35 PM, CNA #2 was observed at the hand washing sink. She slid the large sharps container away from the soap dispenser with her right hand on top of the container near the opening used to discard sharps. Once she washed and rinsed her hands, she pushed the sharps container back toward the soap dispenser and waved her hand in front of the paper towel dispenser to trigger the auto-dispense function. About 12 inches of paper towel was fed from the	F 441		

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F 441	Continued From page 28 dispenser, the leading edge rolled across the top of the second sharps container and exposed 3 inches of paper towel to a potentially contaminated surface. The Infection control nurse stated in interview on 5/11/11 at 11:50 AM sharps containers should not be at a hand washing station, particularly when they contained infectious materials. Observations on 5/11/11 at 1:50 PM revealed staff had removed the sharps containers from the hand washing station. Title 29 of the Code of Federal Regulations, Part 1010, Occupational Safety and Health Standards, Standard 1010.1030, Bloodborne Pathogens, requires employers to provide ready access to hand washing facilities in areas where potential exposure to blood or other potentially infectious material is possible. Further guidance from the Centers for Disease Control and Prevention (CDC), Guidelines for Hand Hygiene in Healthcare Settings, 2002, recommends hand washing be performed in a setting and a manner that prevents recontamination of the hands after washing.	F 441	**F 503 Infection Control/Glucose testing strips** **Lab services, waived testing** • Pioneer Manor will ensure laboratory services that are provided meet applicable requirements for laboratories. This will be accomplished by: • Unit 2, 3 o Glucose monitoring reagents (90 day test strip) and test strips (180 day test strip) labeled with do not use after stickers with appropriate expiration dates. 06/2/11 o Glucose monitoring logs reviewed and staff educated on need to have lot numbers logged when new supplies opened o Just in time training regarding expectations for glucometer supplies and expiration dates 05/12/11	06/26/11
F 503 SS=D	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter.	F 503	All residents with bedside glucose monitoring will have the potential to be affected. All staff / residents have potential to be affected by breach of infection control practices	

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F 503	Continued From page 29 If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of package inserts for laboratory supplies, the facility failed to comply with manufacturer's requirements for whole blood glucose testing at 2 of 3 testing locations. The findings were: On 5/11/11 and 5/12/11, the current lot numbers of glucose test strips and quality control materials on unit 2, 3, and 5 were inspected. The manufacturer's instructions for these supplies were reviewed on 5/12/11; the manufacturer stated in the package inserts that glucose test strips have a 180-day open vial expiration date. Similarly, the liquid quality control material was noted to expire 90 days after opening. Inspection of the vials containing test strips and quality control material failed to show that product expiration dates were modified as required by the manufacturer to reflect the open vial stability for testing supplies found on units 2 and 3. Further	F 503	**F 503 continued** Systemic Processes • Infection Control / Safety Education • Incorporate education into new employee orientation • Do Not use stickers to be used on all multidose vials or bottles with appropriate expiration dates • Revise log to include parameters for expiration dates • Annual competency for glucometers to include expiration dates and QC Outcome measure: 100% glucose monitoring supplies will be labeled with expiration date according to manufacturer recommendations Nursing will monitor glucose monitoring supplies weekly for appropriate documentation of expiration dates Report monthly to QA committee. Immediate education and intervention will occur for all discrepancies	

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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 _____	C 05/12/2011

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F 503	Continued From page 30 review of quality control log sheets on 5/12/11 failed to provide information on lot numbers and dates when new packages of supplies were opened, making it impossible to reconstruct a timeline for in-use dates of new lot numbers. Interview with RN #2 and CNA #2 revealed staff had not read the manufacturer's package insert and were not aware glucose testing supplies had an open vial stability date that reduced the products' potency period. They further acknowledged they did not remember when the current glucose test strips or quality control materials were first opened and placed into use. Title 42 of the Code of Federal Regulations, Part 493, Laboratory Requirements (aka Clinical Laboratory Improvement Amendment [CLIA]), requires that laboratory testing personnel follow the manufacturer's requirements for use, storage, and expiration. Further, reagents and supplies must be labeled with the correct expiration date and are not to be used past expiration.	F 503		06/26/11
F 510 SS=D	483.75(k)(2)(i) RADIOLOGY/DIAGNOSTIC SVCS ONLY WHEN ORDERED The facility must provide or obtain radiology and other diagnostic services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure an electrocardiogram (ECG) was performed every six months as ordered for 1 of 12 sample residents (#107)who had radiology tests ordered.	F 510	**F 510 Diagnostic tests** Pioneer Manor will ensure the facility provides or obtain radiology and other diagnostic services only when ordered by the attending physician Resident # 107 • EKG order discontinued 05/31/11 • All residents have the potential to be affected by errors in scheduling process for diagnostic testing Systemic Processes: • Review all scheduled diagnostic tests in conjunction with medical records and development of process to ensure scheduled diagnostic tests are performed according to schedule • Assignment of coordination of scheduled diagnostic tests to unit secretaries • Develop process to trigger staff awareness of scheduled diagnostic tests • Staff education regarding process for documentation of scheduled routine diagnostic testing • Review and revision of scheduling process	

6/13/11

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F 510	Continued From page 31 The findings were: Review of the signed May 2011 physician's recapitulation of orders for resident #107 showed an order dated 12/8/08 for an electrocardiogrm (ECG) every six months. Review of the medical record, however, revealed no evidence an ECG had been performed in the past year. Interview with the two unit managers on 5/12/11 at 9:15 AM confirmed no ECG had been performed in the past year.	F 510		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the physician recapitulation of orders for May 2011 was accurate for 1 of 19 sample residents (#107). The findings were: Review of the physician's monthly orders for	F 514	**F 514 Complete Accurate Medical Record** Pioneer Manor will ensure the facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. Resident # 107 • Update care plan to reflect current resident status June 2, 2011 • Verify with provider resident current status regarding beard and clarify order June 2, 2011 • Clarify with provider "no wound" and orders for therapy June 2, 2011	06/26/11

6/13/11

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F 514	Continued From page 32 resident #107 showed the following orders which were most likely inaccurate, according to an interview with the two unit managers on 5/12/11 at 9:15 AM: a. There was a 1/27/10 order "Do not shave patient in future, may trim beard PRN." Observation on all days of the survey revealed the resident did not have a beard. b. There was a 5/6/09 order for "physical therapy five times per week for four weeks for debriedement and dressing change." However, observation and medical record review showed the resident had no wound. c. Interview with the two unit managers on 5/12/11 at 9:15 AM revealed the above noted orders were still current valid orders based on being signed by the physician on 5/4/11. Continued interview revealed the nurses were supposed to review all orders one week prior to the physician's visit to see if any clarifications were needed.	F 514	**F514 continued** All residents have the potential to be affected by inaccurate physician orders. Any orders recognized as inconsistent with resident current condition to be clarified and care plan updated. MDS assessment and OPC team to verify and clarify any inconsistent or inaccurate orders during care planning process. <u>Systemic Processes:</u> • Develop process to validate current information for physician • Staff education regarding assessment, intervention, evaluation and documentation of the following o Physician communication and documentation of orders Outcome: 100% of orders will be reviewed for accuracy Nurse Managers or designee to audit 10 charts per week Data will be collected, evaluated and reported at monthly QA meeting with discrepancies evaluated and investigated	

6/13/11