POC accepted 3/30/09 Janelle Conlin 107 12

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

PRINTED: 03/12/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 02/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 9TH 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 244 SS=E	483.15(c)(6) PARTICIPATION IN RESIDENT & FAMILY GROUPS When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes, and interviews with staff, residents, and family members, the facility failed to respond to the resident council regarding a grievance cited by the council during six of the last thirteen monthly meetings. The findings were: Review of resident council meeting minutes for January 2008 through February 2009 were reviewed on 2/24/09. These minutes documented a recurring issue among residents regarding their bathing schedules; six monthly meetings (January, June, August, November, December 2008; January 2009) recorded one or more residents stating they received only one bath or shower a week, when they requested two per week. The council minutes recorded the presence of facility staff at each meeting and in two instances (January 29, 2008 and November 30, 2008) the minutes reflected staff offered assistance to identify and resolve the bathing problems. However, the minutes failed to document any further staff involvement or feedback beyond the initial offer to assist in resolving bathing issues.	F 244	F 244 Pioneer Manor will ensure that resident and family groups complaints and grievances are documented, investigated and results are recorded. Pioneer Manor will make certain that appropriate information regarding the compliant and/or grievance will be communicated to the proper party or parties. This will be accomplished by: A.) The Pioneer Manor will install and utilize a special computer software program (FM Pro) to document and track resident and family complaints. B.) Two staff members will be trained on using this system as well as managers. The two staff members will receive the complaint/grievance and enter compliant/grievance into the FM Pro system. The staff members will make a copy of the compliant/grievance and maintain that copy in secure file area. C.) The compliant/grievance will be sent electronically to the appropriate party or parties for their review. The appropriate party or parties will electronically acknowledge receipt of the compliant/grievance and this will be documented. D.) The party or parties receiving the compliant/grievance will begin an investigation and submit the result of the investigation as well as a recommendation within the required timeframe.	~~4/30/09~~ 4/17/09

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

Stacy Richardson | Interim Admin | 3/26/09

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.

Changed made per phone call with Stacy Richardson Admin at Janelle Conlin on 3/30/09 @ 1130.

MAR 20 2009

Office of Healthcare Licensing and Surveys

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F 244	Continued From page 1 Twelve random resident interviews during the days of survey from 2/23- 2/26/09 revealed the frequency of baths remained a concern and residents stated the facility had not communicated any actions to resolve the issue to the resident council. Five anonymous family interviews on 2/23/09, 2/24/09, and 2/25/09 revealed a similar dissatisfaction with the lack of feedback to residents from the facility. An interview with the resident council president on 2/24/09 at 10:45 AM confirmed bathing continued as a concern for residents attending council meetings. Interview with the facility administrator on 2/25/09 at 2:20 PM revealed a lack of documented action in response to resident council concerns. The facility maintained an incident log, but the log failed to show what actions were taken to resolve grievances arising in resident council meetings or how group concerns were addressed back to the council. The director of nursing (DON) stated in interview on 2/25/09 at 3:10 PM and again at 6:20 PM that she had implemented actions to increase staffing during bath times and had expanded the bathing schedule to include weekends. The DON confirmed the resident council expressed concerns about the frequency of baths. She further stated she had not attended a council meeting to tell them about changes to improve the bathing situation.	F 244	F 244 Continued from page 1 4. communicate changes being done to improve bathing. 5. Nursing Leadership will attend family forum to communicate changes being done to improve bathing. 6. The date on bathing will be monitored by Clinical Supervisors and traced on a quality monitoring tool. 7. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 272	F 272 The facility will ensure that resident #10, #69 and all residents who are on psychotropic medications will have complete documentation of causes and	~~4/30/09~~ 4/17/09

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F 272	Continued From page 2 functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the 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; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to complete comprehensive assessments in various areas for 2 (#10, #69) of 21 sample residents. The findings were: 1. Review of the 12/10/08 annual Minimum Data Set (MDS) assessment showed resident #10 received three different psychotropic medications.	F 272	F 272 Cont. from page 2 contributing factors for medication regimen. This will be accomplished by: 1. Any resident who is on psychotropic medications will have assessment on pre-assessment for antipsychotic medications form by April 1, 2009. 2. All new residents who are ordered on antipsychotic medications will have a pre-assessment for antipsychotic medication form completed on admission. 3. Any changes in conditions and antipsychotic medication are in use, a psychoactive medication quarterly evaluation form will be completed. 4. Any change in medication regimen, a psychoactive medication quarterly evaluation form will be completed. 5. The RAP (Resident Assessment Protocol) will address antipsychotic. 6. The date will be monitored by Clinical Supervisors and tracked on quarterly monitoring tool which will be developed. 7. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meetings for further reviews and recommendations.	

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F 272	Continued From page 3 These included an antipsychotic, an antidepressant, and an antianxiety medication, and the resident received all three daily. Review of the information in the Resident Assessment Protocol (RAP) summary revealed the antipsychotic was not addressed. The remaining information failed to address the causes and contributing factors for the medication regime. Interview with the MDS coordinator on 2/25/09 at 10:05 AM confirmed the assessment was not comprehensive. 2. According to the 2/18/09 annual MDS assessment, resident #69 received an antidepressant medication daily and an antianxiety medication as needed. Review of the assessment information in the RAP summary provided the following information: the medications were reviewed monthly by pharmacy for "interactions" and by the physician on "routine visits" for effectiveness, risks versus benefits, and for the possibility of discontinuing or reducing the dose of the medications. The information failed to address the causes and contributing factors involved in the use of either medication.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) 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.	F 279	F 279 The facility will ensure that resident #44 and all residents care plans will address interventions to prevent and minimize falls. This will be accomplished by: 1. All care plans will address fall risks in accordance with fall assessment on admission. 2. Any changes in condition, a fall assessment will be completed and reflected in the care plan.	~~4/30/09~~ 4/17/09

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F 279	Continued From page 4 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 observation, medical record review, and staff interview, the facility failed to develop a comprehensive care plan for 1 (#44) of 21 sample residents. The findings were: Observation on 2/24/09 at 11:13 AM showed resident #44 was ambulatory with a front wheeled walker. The resident's gait was unsteady and s/he was bent forward over the walker. Review of the assessment information for the 6/12/08 admission Minimum Data Set (MDS) assessment showed the facility assessed the resident as at risk for falls. In addition, review of the 11/26/08 quarterly MDS assessment showed the resident fell within the past 180 days. Furthermore, review of the 2/9/09 fall risk assessment showed the resident's risk of falling was increasing. However, review of the care plan showed the prevention of falls was not addressed. On 2/25/09 at 3:05 PM the director of the facility's fall committee reviewed the care plan and confirmed interventions to prevent or minimize falls were lacking.	F 279	F 279 Continued from page 4 3. Falls team will develop a comprehensive fall assessment form. 4. All falls will be screened by Physical Therapy. 5. Medication review will be completed on all falls. 6. The data will be monitored by falls team and Clinical Supervisors. Tracking will be done on quarterly monitoring tool which will be developed. 7. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendation.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	F 281	F 281 The facility will ensure that resident #14 and all residents orders will be completed or clarified when received. This will be accomplished by:	~~4/30/09~~ 4/17/09

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F 281	Continued From page 5 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by staff interview, the facility failed to complete or clarify physician orders for 3 (#14, #44, and #56) of 21 sample residents. The findings were: 1. Review of a physician's order, dated 1/22/09, requested a hospice consult for resident #14. Review of nurses' notes dated 1/29/09 showed the resident was improving and questioned the need to continue with the hospice consult. Additional review of the resident's medical record failed to show any further action to complete or clarify the physician's initial order. Licensed Practical Nurse (LPN) #3 stated in interview on 2/24/09 at 1:10 PM she did not know if the consult had been completed or canceled. She called the hospice nurse at 1:30 PM and discovered no consult was ever done. LPN#3 confirmed the lack of documentation to cancel or clarify the physician's order. 2. A physician's order, dated 12/11/09, requested laboratory work be performed on resident #56. The requests included thyroid stimulating hormone (TSH) to monitor the resident's hypothyroid therapy. As of 2/25/09 at 10:30 AM, the results of the TSH test were not posted in the resident's medical record. Interview with LPN #4 on 2/25/09 at 10:45 AM revealed nursing staff was responsible for transcribing the physician's order onto a request for the laboratory. She confirmed the physician's order for the TSH test, but was unable to find evidence the order had been forwarded to the laboratory. A laboratory	F 281	F 281 Continued from page 5 1. LPN #3 and all nurses will document status of order, sign, date and time of completion or clarification. a.) Log will be developed to address orders sent for clarification. This log will also address when sent and received back with individual nurses' signature, date and time. b.) Consults will be tracked for when requested and completed. 2. The data will be monitored by Clinical Supervisors and tracked by quality monitoring tool which will be developed. 3. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations. The facility will ensure that #56 and all resident's physician orders will be carried out to completion. This will be accomplished by: 1. Develop a tracking sheet for procedures which will show the following: a.) Resident b.) Physician order and date c.) Date drawn and time d.) Result, date and time e.) Lab result in chart and fax to physician. Nurse signature, date, time and when placed in chart.	

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F 281	Continued From page 6 receptionist was interviewed by telephone on 2/25/09 at 9:40 AM; she confirmed a TSH level had not been requested by facility staff for resident #56. 3. According to the January 2009 recapitulation of orders form, resident #44 was to receive oxygen at 2 liters per minute per nasal cannula. Observation on 2/24/08 from 7:30 AM until 3:40 PM and again on 2/25/09 at 11:18 AM and 11:38 AM showed the resident was not routinely utilizing oxygen. On 2/25/09 at 10:33 AM clinical supervisor #1 stated the resident did not use oxygen and had not for a "long time." She confirmed the physician's order had not been followed or clarified. According to the Wyoming State Nursing Practice Act July 2005 and Administrative Rules and Regulations November 2003, nurses shall practice under the direction of a physician. Interview with the director of nursing (DON) on 2/25/09 at 6:20 PM revealed the facility's expectation that physician orders be completed or clarified, with documentation in the medical record to show the outcome. The DON further stated nursing staff were expected to review physician's orders and ensure all requested actions were completed.	F 281	F 281 Continued from page 6 2. The data will be monitored by Clinical Supervisors and tracked by quarterly monitoring tool which will be developed. 3. The DON or designee will report the finding of quality monitoring to the QIC at the quarterly meeting for further review and recommendations. The facility will ensure that #44 and all resident's orders will be reviewed and all requested action were completed. This will be accomplished by: 1. Upon receiving orders, nurse will review it and all requested actions are completed and documented on order, completed by, signed, dated and timed. 2. Medications and treatments when competed will be pinked out. Sign, date and time. 3. The date will be monitored by Clinical Supervisors and traced by quarterly monitoring tool which will be developed.	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 282	F 282 Refer to F309 and F315 for details regarding lack of incontinence care and services according to the plan of care for resident #114.	~~4/30/09~~ 4/17/10

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F 282	Continued From page 7 and staff interview, the facility failed to ensure a care plan was followed for 1 (#114) of 21 sample residents. The findings were: Refer to F309 and F315 for details regarding lack of incontinence care and services according to the plan of care for resident #114.	F 282		
F 309 SS=D	483.25 QUALITY OF CARE 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 interview, the facility failed to ensure appropriate care and services was provided for 1 (#114) of 3 sample residents with bowel incontinence. The findings were: Observation on 2/24/09 from 7:45 AM to 10:40 AM (2 hours and 55 minutes) showed resident #114 was not checked for bowel incontinence. The resident was found to be incontinent of feces when checked at 10:40 AM by certified nurse aide (CNA) #1 Review of the 8/27/09 significant change minimum data set (MDS) assessment revealed the resident was occasionally incontinent of bowel and was totally dependent on staff in all activities of daily living. Interview with CNA #1 on 2/24/09 at 10:50 AM revealed staff were to follow the care plan and check the resident every two hours for bowel incontinence.	F 309	F 309 The facility will ensure that #114 and all resident's will receive appropriate care and services with bowel incontinence. This will be accomplished by: 1. Bowel assessment form will be completed on admission, quarterly, annually and with significant change. 2. Care plan will address bowel plan to be followed. 3. Form will be developed to track time frames for assessments. 4. The data will be monitored by Clinical Supervisors and traced by quality monitoring tool which will be developed. 5. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendation. Staff will be in-serviced regarding following Care plans.	4/30/09 4/17/09

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F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate care and services for incontinence was provided for 1 (#114) of 7 sample residents with bladder incontinence. The findings were: Observation of resident #114 on 2/24/09 from 7:45 AM to 10:40 AM (2 hours and 55 minutes) showed s/he was not checked for bladder incontinence. When the resident was checked for incontinence at 10:40 AM, s/he was found to be incontinent of urine. Review of the 8/27/09 significant change minimum data set (MDS) assessment for the resident showed s/he was usually incontinent of bladder and was totally dependent on staff for all activities of daily living. Interview with certified nurse aide #1 on 2/24/09 at 10:50 AM revealed staff were to follow the care plan and check the resident every two hours for bladder incontinence.	F 316	F 315 The facility will ensure that #114 and all residents will receive appropriate care and services with bladder incontinence. This will be accomplished by: 1. Bladder assessment form will be completed on admission, quarterly, annually and with significant change. 2. Care plan will address bladder plan to be followed. 3. Form will be developed to track time frames for assessment. 4. The data will be monitored by Clinical Supervisors and tracked by quality monitoring tool which will be developed. 5. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations. Staff will be in-serviced regarding following the care plan.	~~4/30/09~~ 4/17/09
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards	F 323	F 323 The facility will ensure that #82, #89, #10, #44 and all residents will have an environment as free from accident hazards	~~4/30/09~~ 4/17/09

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F 323	Continued From page 9 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, medical record review, and staff interview, the facility failed to assure the environment was free of accident hazards for 4 (#82, #89, #10, #44) of 4 sample residents with side rails and in four of four neighborhoods with regard to hot water temperatures. The findings were: SIDE RAILS: 1. Observation on 2/24/09 at 7:20 AM revealed resident #82 had a specialized air bed, which was away from the walls and had full side rails in the upright position. Review of the 12/17/08 quarterly MDS assessment revealed the resident required extensive assistance for bed mobility and transfers. Further review of the medical record showed a safety assessment related to the use of bed rails was lacking. Interview with the director of nursing (DON) on 2/25/09 at 4:05 PM revealed the rails were used in conjunction with this air mattress type in order to prevent the resident from falling out of bed. At that time the DON verified there had not been any type of safety assessment done. 2. Observation on 2/24/09 at 7:40 AM and at 1:45 PM revealed resident #89 was in bed with two half rails in the raised position. The bed rails were positioned in the middle third of the bed. There	F 323	F 323 Continued from page 9 as possible. Each resident will receive adequate supervision and assistance devices to prevent accidents. This will be accomplished by; Side rails: 1. All residents will have a side rail assessment complete to ensure non entrapment. a.) Side rail assessment form will be completed. b.) Bed System Measurement Device will be used for safety assessment. 2. Side rail assessment will be completed when mattress and/or side rails changed. 3. Side rail assessment will be completed with a significant change in condition. 4. The data will be collected by equipment inventory clerk and report given to DON. This will be tracked by quarterly monitoring tool which will be developed. 5. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations. 6. Date will also be reported to EOC at monthly meeting by DON or designee.	

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F 323	Continued From page 10 was enough space between the rails for an arm or leg to fit through. Interview on 2/24/09 at 7:45 AM with certified nurse aides (CNAs) #2 and #3 revealed the resident tried to get out of bed by herself. Review of the 2/4/09 quarterly Minimum Data Set (MDS) assessment showed the resident had impaired cognition, required limited assistance with bed mobility, and used bed rails for mobility or transfer. Review of the medical record showed no assessment was done to determine if the bed rails were safe for this resident. During an interview on 2/25/09 at 4:20 PM, the DON verified there had not been a safety assessment completed related to bed rail use for this resident. 3. Observation on 2/24/09 at 8:07 AM revealed resident #10 was sleeping with two half bed rails elevated. According to the 12/10/08 annual Minimum Data Set (MDS) assessment, the resident used the rails for mobility and transfers. However, review of the medical record failed to show a safety assessment for use of the rails. On 2/25/09 at 3:05 PM, the director of the facility's fall committee stated the facility did not evaluate side rails for safety. 4. Observation on 2/24/09 at 8:15 AM, 10 AM, and 11:05 AM showed resident #44 was sleeping in bed with the back half bed rail elevated. Review of the 11/28/08 quarterly MDS assessment showed the resident was coded as using the rail for mobility and transfers. Review of the entire medical record showed a safety assessment for use of the rail was lacking. Interview with the director of the facility's fall committee on 2/25/09 at 3:05 PM verified safety assessments with use of side rails had not been completed.	F 323	F 323 Continued from page 10 The survey revealed that in some of the resident rooms the hot water temperature exceeded state standards. To remedy this situation, Plant Operations adjusted mixing valves which resolved the problem. Plant Operations will monitor water temperature on a periodic basis to ensure compliance.	3/24/09 9/10/09

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F 323	Continued From page 11 WATER TEMPERATURES 1. Observation on 2/25/09 at 9:30 AM revealed the following water temperatures at sinks: a. Room #219 - 120 degrees F b. Room #215 - 122 degrees F c. Room #209 - 122 degrees F d. Room #102 - 126 degrees F e. Room #111 - 124 degrees F f. Room #308 - 120 degrees F g. Room #318 - 120 degrees F h. Room #522 - 134 degrees F I. The women's bathroom outside of the chapel - 130 degrees F. 2. Interview on 2/25/09 at 10:15 AM with maintenance technician #1 revealed they took temperatures at the resident sinks about once a month, but did document any of the checks. He stated when the temperatures were checked, they were "usually 120 to 123 degrees." 3. According to the American Burn Association (www.ameriburn.org/Preven/ScaldInjuryEducator'sGuide.pdf), third degree burns can occur within the following times, based on temperature; 120 degrees - 5 minutes; 124 degrees - 3 minutes; 127 degrees - 1 minute; 133 degrees - 15 seconds; 140 degrees - 5 seconds.	F 323		
F 329 SS=D	483.25(l) 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.	F 329	F 329 The facility will ensure that #10, #95 and all resident's drug regimens are free of unnecessary medications. This will be accomplished by: 1. Pharmacy consult sheets are completed on each resident monthly. a.) Forms sent to physician and reviewed.	~~4/30/09~~ 4/10/09

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F 329	Continued From page 12 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 2 (#10, #95) of 21 sample residents' drug regimens were free of unnecessary medications. The findings were: 1. According to the physician's orders and the medication administration records, resident #10 had received Thorazine 25 milligrams (mg) once daily, Trazodone 100 mg once daily, and Ativan 1 mg four times a day since 1/4/05. These are, respectively, an antipsychotic, an antidepressant, and an antianxiety medication. Review of the medical record showed no evidence a dose reduction for any of the medications had been attempted. Nor was there any evidence the physician had determined whether or not reducing the dosage of these medications was clinically contraindicated. On 2/24/09 at 4:30 PM the DON confirmed a dose reduction had not been attempted. Furthermore, she confirmed the	F 329	F 329 Continued from page 12 b.) Physician will respond to pharmacy note, sign, date and time pharmacy consult form. c.) Copy of form is sent to DON for tracking. 2. Risk and benefits will be determined by physician and address with clinical evidence to reduce or not. 3. Pharmacy will monitor for unnecessary drugs and risk and benefits. Addressing such on pharmacy consult form. 4. The data will be monitored by pharmacy and DON and tracked by quality monitoring tool which will be developed. 5. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations.	

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F 329	Continued From page 13 physician had not provided a clinical rationale as to whether or not a dosage reduction was contraindicated. 2. Review of physician orders showed resident #95 was prescribed Zyprexa 10 milligrams daily since 9/19/07 to treat anxiety and paranoia. Review of the medical record revealed there was no indication the Zyprexa had been reduced or any note from the physician to indicate a dose reduction was contraindicated. Interview with the DON on 2/25/09 at 4:05 PM revealed she was unable to find any information related to either a dose reduction or contraindication for resident #95's Zyprexa.	F 329		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of the facility's reference book, and staff interview, the facility failed to maintain a medication error rate under five percent (%). Three errors occurred out of 51 opportunities for error, resulting in an error rate of 5.88%. The findings were: 1. Observation on 2/23/09 showed licensed practical nurse (LPN) #1 prepared and administered medications to resident #118 at 6:23 PM. These medications included Vytorin 10/20 milligrams (mg). Reconciliation of the medication pass with the physician's orders showed the physician ordered simvastatin 20 mg.	F 332	F 332 The facility will ensure that #118, #40, #72 and all resident's medications will have a reconciliation of the medication pass with physician's orders. This will be accomplished by: 1. Pharmacy will do all medication order sheets. 2. All medication substitutes will be okayed by ordering physician in writing. 3. Medications will be given at times ordered by physician. 4. The data will be monitored by the Clinical Supervisors and tracked by quality monitoring tool which will be developed. 5. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations. will provide education to RN's + LPN's.	~~4/30/09~~ 4/17/09

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F 332	Continued From page 14 Review of the facility's medication reference book showed Vytorin is a combination of simvastatin and another drug. On 2/24/09 at 10:05 AM the DON stated she checked with the pharmacy department, and they did not have physician approval to substitute Vytorin for simvastatin. 2. On 2/24/09 at 4:40 PM, LPN #2 was observed preparing and administering medications, including oystershell calcium 500 mg with vitamin D 200 mg, to resident #40. Reconciliation of the medications with the December 2008 recapitulation of orders showed the physician's order was for Oystercal 250 mg. On 2/24/09 at 5:45 PM the DON confirmed the wrong medication had been administered. 3. Observation of a medication pass on 2/25/09 at 12 noon revealed registered nurse (RN) #1 administered 28 units of Lantus insulin subcutaneously in the abdomen to resident #72. Review of the medical record for the resident revealed an order for Lantus insulin dated 12/26/08 which read, "Lantus 28 units, give subcutaneously at 7 AM daily for type II diabetes." Interview with RN #1 on 2/25/09 at 12 noon revealed she had been administering Lantus insulin to the resident at lunch each day; "because the resident sleeps late." The nurse further stated she should discuss the time discrepancy concerning administration of the Lantus insulin with the ordering physician.	F 332		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW 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	F 428	F 428 Facility will ensure that #10, #44, #52, #64, #89, #95, #107 and all resident's that their drugs regimens are reviewed monthly by a licensed Pharmacist and potential	4/30/09 4/17/09

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F 428	Continued From page 15 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 medical record review, and staff and resident interviews, the facility failed to ensure drug regimens were reviewed monthly by a pharmacist; that the pharmacist identified all potential irregularities; or that the physicians acted upon the reports for 7 (#10, #44, #52, #64, #89, #95, #107) of 21 sample residents. The findings were: Missing monthly medication reviews (MMRs): 1. Review of the medical record face sheet showed resident #52 was admitted to the facility on 12/31/08. Review of the pharmacy MMRs for the resident revealed there was not a review done for the month of January 2009. Interview with the of DON on 2/25/09 at 4:05 PM confirmed the January 2009 review was not done. 2. Review of the pharmacist reviews for resident #89 revealed no MMRs for September or October 2008. During an interview on 2/25/09 at 11 AM, the DON stated there were no pharmacy reviews for those two months. She stated she called the pharmacy, and they didn't have anything. 3. Review of the pharmacist reviews for resident #107 showed no MMR for September 2008. During an interview on 2/25/09 at 11 AM, the DON stated there was no pharmacy review for	F 428	F 428 Continued from page 15 irregularities are acted upon by physician. This will be accomplished by: 1. Pharmacist fills out pharmacy consult form. 2. Pharmacy consult form is sent to physician by nursing with copy in chart. a.) When original returns – copy goes in DON folder with document response of physician. 3. Tracking form for all residents to be developed to ensure review is completed each month. 4. Data will be monitored by DON and tracked by quarterly monitoring tool which will be developed. 5. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations. the pharmacist will reviews PRN medications.	

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F 428	Continued From page 16 that month. She stated she called the pharmacy, and they didn't have any other documentation to review. Pharmacist not recognizing irregularity: Review of the January and February 2009 medication administration records (MARs) for resident #52 revealed s/he had physician orders beginning on 1/5/09 for Vicodin 5/500 tabs every four hours as needed (PRN) for pain. According to the MARs the resident received 50 doses of the PRN pain medication in January 2009 and 86 doses from 2/1 to 2/24/09. Review of the February 2009 MMR showed the pharmacist did not address the routine use of the PRN pain medication as an irregularity. Interview with the DON on 2/25/09 at 4:05 PM revealed the routine use of the PRN medication had not been addressed. Interview with the resident on 2/25/09 at 5 PM revealed his/her pain was controlled; however, the resident would rather have the pills on a regular schedule so s/he didn't have to ask for them. Lack of MD response to pharmacist recommendation: 1. Review of the October 2008 pharmacy consult for resident #95 showed the pharmacist recommended an attempt to reduce the resident's Zyprexa. There was no evidence in the medical record that the physician responded to this recommendation, or that any reduction was made to the medication. Interview with the DON on 2/25/09 at 4:05 PM verified she was unable to find any response from the physician related to the pharmacist's review.	F 428		

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F 428	Continued From page 17 2. According to the physician's orders and the medication administration records, resident #10 had received Thorazine 25 milligrams (mg) once daily, Trazodone 100 mg once daily, and Ativan 1 mg four times a day since 1/4/05. Review of the monthly medication regime review (MRR) for resident #10 showed on 1/08, 6/08, 10/08, and 11/08 the pharmacist requested the physician "list the risks vs benefits of Thorazine, Trazodone and Ativan." Review of the medical record showed no response from the physician related to these requests. On 2/24/09 at 4:30 PM, the DON confirmed the physician's response was lacking. 3. Review of the physician's orders showed resident #44 received Prozac 20 mg twice daily and Pepcid 20 mg twice daily. Review of the pharmacist's 1/13/09 "Physician Action Report" for the resident showed the pharmacist requested the physician "review risk vs. benefit" of increasing the resident's Prozac. Further review showed, that due to the resident's creatinine clearance, the pharmacist also requested, on 11/08 and 12/08, that the physician decrease the resident's Pepcid dose to once daily. None of these requests were signed by the physician and the medication dosages remained unchanged. Interview with the DON on 2/24/09 at 4:30 PM revealed the physician signed the pharmacist's MRRs when an irregularity was identified or a request made. At this time, she confirmed the MRRs had not been signed by the physician, and there was no evidence the physician was aware of the irregularity. 4. Review of the pharmacist's monthly MRR for the past year showed the pharmacist identified irregularities in September, October, and November of 2008 for resident #69. On 2/24/09 at	F 428		

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F 428	Continued From page 18 4:30 PM the DON stated that the physician signed the pharmacist's reviews when an irregularity was identified or a request made. Review of the MRRs by the DON on 2/25/09 at 3:30 PM verified they were not signed by the physician. Since the recommendation had not been followed, there was no evidence the physician was actually aware of the irregularity.	F 428		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure 1 (#69) of 1 resident who did her/his own colostomy care was trained in infection control techniques and monitored for compliance with appropriate hand hygiene standards. The findings were: During an interview on 2/26/09 at 3:50 PM, resident #69 stated s/he changed his/her own colostomy bag at night. The resident further stated, and observation at that time confirmed, that s/he could not wear gloves due to contractures in her/his fingers and hands. The resident added feces "...goes everywhere..."	F 441	F 441 The facility will ensure #69 and all residents will obtain document training on infection control techniques and monitored for compliance with appropriate hand hygiene standards. This will be accomplished by: 1. Ostomy care will be completed by nursing staff unless specifically documented on care plan. 2. Specific documentation/education for independent care is as follows: a.) Evaluate feasibility of resident performing task. b.) Educate in self performance of task including infection control technique. c.) Return demonstration of performance of task. d.) Check off list developed for each task and signed by instructor and resident/family. e.) Check off list placed in chart. Result will be care planned. 3. Monitor procedure for compliance of infection control precautions. 4. Annually monitoring of self performed task will be tracked by	~~4/30/09~~ 4/17/09

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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
	535022	A. BUILDING _____ B. WING _____	C 02/26/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 19 referring to the wheelchair, bed, bathroom, and the her/his body and clothing. The resident stated her/his spouse sometimes changed the colostomy bag. The spouse was present at the interview and agreed with that statement. The following concerns were identified related to infection control practices: a. Review of the resident's medical record failed to show evidence the resident was evaluated or educated to provide self-care for her/his colostomy. The record further revealed the resident had chronic urinary tract infections, to include a history of positive cultures for methicillin-resistant Staphylococcous aureus (MRSA). b. Review of the resident's current care plan, dated 2/7/09, failed to show any goals related to the resident's self-management of the colostomy. There were also no goals related to catheter care for this resident. In addition, the plan did not address infection control precautions associated with the resident's history of MRSA colonization. Further, the care plan lacked interventions to ensure both the resident and spouse learned and practiced proper hand hygiene appropriate for the level of care they performed. The DON confirmed in interview on 2/26/09 at 11:10 AM resident #69 and her/his spouse changed the colostomy bag and, at times, the resident's catheter bag. She confirmed staff had not educated, and were not monitoring the resident for infection control precautions or hand washing techniques appropriate for this level of self-care.	F 441	F 441 Continued from page 19 Clinical Supervisors and check list will be completed and placed in chart. 5. If significant change occurs, new check list will be completed and placed in chart. Result will be care planned. 6. The data will be monitored by Clinical Supervisors and tracked by quality monitoring tool which will be developed. 7. The DON or designee will report the findings of quality monitoring to the QIC at the quarterly meeting for further review and recommendations.	
F 520 SS=C	483.75(e)(1) QUALITY ASSESSMENT AND ASSURANCE	F 520	F 520 Facility will ensure that physician is present at quality assurance meetings. This will be accomplished by:	~~4/30/09~~ 4/17/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 520	Continued From page 20 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of quality assurance (QA) meeting minutes, the facility failed to ensure the QA committee had included a physician for the past year. The findings were: Review of the QA meeting minutes dated 4/17/08, 7/17/08, 10/16/08 and 1/15/09 revealed there was not any physician among those present. Interview with the DON on 2/26/09 at 9:50 AM confirmed a physician was not part of these meetings.	F 520	F 520 Continued from page 20 1. Meeting with Medical Director and educate importance of being present at meetings. 2. New date set for QIC quarterly meetings. 3. All members notified of new date. 4. DON will send reminder of meeting to all members the week before..	