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

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 _____ 4/27/07	03/01/2007

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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	F225 The facility will ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property will be reported to the administrator of the facility and other officials in accordance with State law through established procedures (including to the State survey and certification agency). This will be accomplished by: 1. The facility was instructed by the Office of Healthcare Licensing and Surveys to follow proper procedure of notification of state agencies and local law enforcement regarding alleged violations going forward from the date of this survey. 2. All cases of alleged violations of residents' rights from the time of the survey going forward will be reviewed by the Administrator (NHA) to ensure that the appropriate notification steps were/are taken as per the State requirements. 3. A revision of the facility policy now includes that all alleged violations will be reported to the ADM or designee of Pioneer Manor immediately and will then be reported to the state agencies, Department of Family services and/or local law enforcement	3/22/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda K. Gallup	Administrator	3/28/07

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.

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F 225	Continued From page 1 by: Based on staff interview and review of completed internal investigations, the facility failed to report two of two allegations of abuse to the Department of Family Services (DFS) or to a law enforcement agency as required by Wyoming State Statute 35-20-103. The findings were: Interview with two social workers, employees #14 and #20, and the director of nursing (DON) on 2/28/07 at 2 PM revealed the facility did not report allegations of abuse, neglect, or misappropriation of property to the police or to DFS. The social workers and DON stated they were instructed by the police and DFS to conduct an internal investigation and to then contact the aforementioned agencies only if they substantiated the allegation. Review of two abuse allegations, dated 11/1/06 and 1/15/07, verified neither the police nor DFS were notified. According to State Statutes 35-20-101 through 35-20-116 (Adult Protective Services Act) the requirements for reporting are as follows: 35-20-103 (a) Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the department (DFS).	F 225	Continued From page 1 agency. The investigation will follow State Statues 35-20-101 through 35-20-116. The immediate notification will be followed by a thorough internal investigation within 5 working days of the ~~original notification via facsimile.~~ incident The original report documents will be mailed to all appropriate agencies per facility policy. 4. The Social Services Department (SSD) staff will develop and maintain a quality monitor tool. Investigation checklists will be updated and used to document the required steps of the investigation. The ADM and/or Director of Nursing (DON) will monitor the checklists at start of process for appropriate completion and notification. Results of the monitoring tool will be presented to the Quality Improvement Committee (QIC) for further review and recommendations. 5. All steps will be implemented by 3/22/07.	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241	F241 The facility will ensure that care for residents are provided in a manner and in an environment that maintains or enhances each resident's dignity and	3/22/07

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F 241	Continued From page 2 by: Based on observation and resident and staff interviews, the facility failed to provide dignified dining experiences for one non-sample (#40) and two sample (#27, #65) residents during three of three meals. The findings were: 1. Observation on 2/27/07 at 7:35 AM showed resident #40 sitting up in bed eating breakfast. The meal consisted of a fried egg, bacon, toast, pears, cooked cereal, milk, and juice. Certified nurse aides (CNAs) #12 and #16 entered the room with a mechanical lift and told the resident they would get him/her up in a chair for breakfast. The resident was not given the option to finish the meal. After the resident was transferred to the wheelchair, the CNAs, placed the leg and foot supports on the wheelchair, made the bed, washed the resident's face, provided personal grooming, cleaned the resident's glasses, and placed the glasses and oxygen cannula on the resident. Ten minutes later, at 7:45 AM, breakfast was again placed in front of the resident and the CNAs left the room. At that time the resident said the breakfast was "getting cold." The resident stated s/he was not asked prior to 7:35 AM if s/he wanted to get up before eating. The resident further stated s/he would have preferred to get up after breakfast. Observation at 8:57 AM revealed the resident ate cooked cereal and pears. On 2/28/07 at 12:52 PM the director of nursing (DON) stated the CNAs should have waited for the resident to finish breakfast before providing cares. She further stated meals should not be brought into the rooms if the residents were not up. 2. According to the 2/21//07 quarterly Minimum Data Set (MDS) assessment, resident #27 had	F 241	Continued From page 2 respect in full recognition of his or her individuality. 1. Resident # 40 – Certified Nursing Assistants (C.N.A.) have been instructed on 2/28/07 to allow this resident free choice in whether she wants to eat first or get dressed and out of bed first. His meals are to be kept covered and proper temperature maintained until he is ready to eat. Residents # 27 and 65; CNA's were instructed to serve meals to these residents when they were alert and awake enough to eat and when the staff was available to sit and assist them with eating. 2. All residents who are dependent on staff to assist them in preparing for meal service or in actual feeding, cueing or in need of direct supervision could be impacted by this practice. The Dietary Manager (DM) or DON/designee will monitor all dining rooms during meal service to identify those residents who may need more assistance and to ensure food is not delivered until the resident is ready. 3. Nutrition Services management staff will provide in-service training to dietary staff and CNAs on the importance of food temperatures and how to maintain required temperatures prior to serving and	

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F 241	Continued From page 3 severe cognitive impairment and was totally dependent on staff for assistance with meals. Observation on 2/26/07 at 5:23 PM revealed the resident was sleeping when his/her meal was served. The meal was served uncovered and noted to consist of ground sausage and French toast cut in small pieces. Although CNA #7 was seated on the opposite side of the table, she did not attempt to awaken the resident. Twenty minutes later, at 5:43 PM, licensed practical nurse (LPN) #3 attempted to give the resident a bite of food without warming the meal. The resident pursed his/her lips and refused to eat. On 2/28/07 at 12:52 PM, the DON stated staff were to assist residents at the time the meal was served. Observation on 2/27/07 at 6:34 PM revealed the resident was served his/her evening meal. The meal was again noted to be uncovered. No meal assistance was provided until 6:50 PM, 16 minutes after the meal had initially been served. At that time, an unidentified staff member attempted to feed the resident. The resident again pursed his/her lips and refused to eat. At 3 PM on 2/28/07 the DON stated pureed food would not have had any heat left after that length of time. On 2/28/07 at 12:52 PM, the DON stated staff were expected to assist residents at the time the meal was served. 3. Review of the 1/17/07 quarterly MDS assessment showed resident #65 required extensive staff assistance with meals. Observation on 2/26/07 at 5:23 PM showed the resident's evening meal had just been served, but the resident was not eating. CNA #7 sat down at the table across from the resident at 5:39 PM, but did not speak to, cue, or otherwise attempt to assist the resident. No other staff person cued or	F 241	Continued From page 3 immediately following serving food to all residents by 4/1/07. Staff Development Coordinator (SDC) and DON will provide in-service education to CNAs on resident dignity, which will include providing resident #40 and all residents when they choose to get out of bed and receive cares. Meals will not be placed for dining unless residents are ready and prepared to eat. Dietary and Nursing have reviewed the meal service process and have modified the system. Independent residents will be served first, and then assisted diners and then residents receiving room trays will be served last. The dietary staff on the serving line will receive in-service training on observing or listening when told by staff delivering meals when residents are seated and ready to dine or not and serve up trays accordingly. If a tray is prepared and the resident is not ready to dine the tray will be placed in refrigeration and the hot portion reheated when the resident(s) is ready to dine. This process initiated 3/22/07. The DM, DON or designee will monitor this process and recommend changes and additional training as needed. 4. The DM and DON will develop a monitoring tool for this process. The results of this monitoring tool will be presented to the QIC for further review and recommendations. 3/22/07	

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F 241	Continued From page 4 assisted the resident until 5:44 PM (21 minutes later), when LPN #3 assisted the resident to eat. There was no attempt made to check the temperature of the food prior to assisting the resident. Interview with the DON on 2/26/07 at 12:52 PM verified the facility's expectation was that the CNA should have assisted the resident at the time the meal was served.	F 241		
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 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	F 272	F272 The facility will conduct initial and periodic comprehensive, accurate standardized assessments of each resident's functional capacity. This will be accomplished by: 1. A comprehensive assessment of resident # 52 was completed to determine the need for a Foley catheter. The foley was removed on 3/5/07. 2. All residents with Foley catheters have been assessed to determine if the catheter is appropriate. This was completed 3/5/07. 3. On 3/29/07 the SDC and DON will conduct an in-service for professional nursing staff regarding the completion of a comprehensive assessment for all residents admitted with a Foley catheter. If the catheter can be removed bladder training will begin as soon as possible after the removal of the catheter and the process will be documented. The DON or designee will audit any resident with a Foley catheter to determine appropriateness and follow-up care if applicable.	3/31/07

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F 272	Continued From page 5 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 perform a comprehensive assessment for one (#52) of two sample residents with indwelling urinary catheters. The findings were: Observation on 2/26/07 at 5:30 PM showed resident #52 had a catheter. Medical record review revealed resident was admitted to the facility on 9/1/06 with an catheter. Review of the admission Minimum Data Set assessment confirmed the resident had a catheter. However, there was no information in the record as to why a catheter was being utilized or the diagnosis for the catheter. Interview with the director of nursing (DON) on 3/1/07 at 8:30 AM revealed that catheter's for residents who were admitted with indwelling catheters would normally be removed "as soon as possible." The DON further stated a resident with a catheter would be assessed upon admission, and periodically thereafter for the reason the catheter was being utilized. Interview with the DON on 3/1/07 at 10 AM verified a comprehensive assessment for this resident's catheter had not been done.	F 272	Continued From page 5 4. A quality-monitoring tool will be implemented by the DON or designee and presented to the QIC for further review and recommendations. 3/31/07	
F 282 SS=E	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.	F 282		

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F 282	Continued From page 6	F 282	F282 The facility will ensure that services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. This will be accomplished by: 1. The plan of care was reviewed for residents # 27, 29, 43, 73 and 93. The plan of care matches their current status relative to incontinence management, the provision of thickened liquids and the provision of scheduled baths and that staff are providing the planned services as scheduled. On 2/28/07 staff were in-serviced on incontinence management. Provision of thicken liquids was in-serviced to CNAs. Sunshiners were instructed not to pass fluids to these residents; list provided for them. Reviewed with staff about importance of bathing with documentation in record of type of bath, tolerance and skin assessment. 2. All residents who are incontinent, need thickened liquids or are bathed by staff could be impacted by this practice cited. All residents who fall into these categories were reviewed to ensure that services were being provided. The DON completed this review 3/5/07.	3/31/07

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, and staff interview, the facility failed to provide planned care for six (#27, #29, #43, #65, #73, #93) of 20 sample residents. The facility failed to follow the plan of care for residents in the areas incontinence management (#65, #73), the provision of thickend liquids (#65), and the provision of scheduled baths (#27, #29, #43, #93). The findings were:

1. Continuous observation on 2/28/07 from 1 PM until 4:43 PM revealed the following concerns related to resident #65 and staff failure to provide care as planned:

a. The 3 hour and 43 minute observation revealed staff did not assist, cue, or check the resident for incontinence. Review of the resident's most recent plan of care, with a run date of 1/30/07, revealed the resident required staff assistance with incontinence, and was on the facility's "keep dry" program. Review of the undated incontinence program revealed residents on the "keep dry" program used incontinence briefs and required checking every 2 to 3 hours. The observation revealed no one checked the resident for three hours and 46 minutes until the surveyor intervened and requested the resident be checked. Interview with the director of nursing (DON) on 2/28/07 at 4:43 PM revealed the staff was expected to assist this resident according to the plan of care.

b. Review of the resident's plan of care, with a run date of 1/30/07, revealed the resident required assistance with intake and should received "nectar thick" liquids. Further record

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F 282	Continued From page 7 review revealed a care plan for dehydration. One of the interventions listed was "encourage fluid intake between 1000 and 1500 ml (milliliters) per 24 hours. During the aforementioned observation, the resident was at the nurses' stations seated in a wheelchair. At 3:20 PM, a secretarial staff member wheeled the resident into the Neighborhood 5 dining room and gave the resident a coffee mug of water. From 3:20 PM until 4:43 PM, the resident took one sip of the water, and attempted to take another sip when activity staff cued another resident to drink at 4:34 PM. Interview with the DON at 4:43 PM revealed the resident had water and not the thickened liquids which the resident required. Interview with licensed practical nurse #10 and the Neighborhood 5 unit secretary #6 on 2/28/07 at 4:28 PM revealed the intake for resident #65 was not monitored or measured. 2. Review of the medical record for resident #29 revealed a December 2006 bath record that documented the resident received three baths during December on 12/4/06, 12/14/06 and 12/28/06. Review of nursing notes failed to reveal refusals or rescheduled days. The notes documented concerns related to vaginal drainage on 12/2/06 and 12/23/06 that staff documented as "foul smelling." Review of the resident's most recent plan of care, with a run date of 1/5/07, revealed the resident required total staff assistance to bathe in the "lay down" tub. The care plan also documented that the resident required two baths a week. Interview with the DON on 2/28/07 at 3 PM revealed she did not know why staff only documented three baths during the month of December for the resident. 3. According to the 12/13/06 significant change	F 282	Continued From page 7 3. The DON and SDC conducted in-services for CNAs on resident incontinence programs and the facility's "keep dry" plan, the need to keep residents appropriately hydrated by encouraging the intake of liquids, including thickened liquids and on the importance of bath and skin assessments on (3/16/07). CNAs were instructed to inform charge nurses if a change occurs with a resident so that appropriate steps can be taken to ensure ongoing needs and services are met. Clinical supervisors will ensure the implementation of the "keep dry" program and track compliance on a weekly basis. The clinical supervisors will monitor residents in their areas to ensure that appropriate fluids are being offered and track compliance on a weekly basis. Clinical supervisors will monitor residents in their areas to ensure that bathing and skin checks occur as care planned on a weekly basis. CNAs will carry resident care plans, which are condensed versions in their pockets during working hours for a quick referral on specific resident needs. 4. The DON or designee will review the weekly monitoring tools	

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F 282	Continued From page 8 Minimum Data Set (MDS) assessment, resident #73 had moderately impaired cognition (required cues and supervision) and was totally dependent on staff for bathing and toileting. Review of the 12/22/06 care plan showed the resident was to be bathed twice a week and was on the "keep dry" program for toileting. The following concerns with failure to follow the care plan were identified: a. Review of the bathing records showed the resident did not receive two baths per week during the weeks of December 3rd and 24th in 2006; January 21st in 2007; and February 18th in 2007. No other reasons for not having baths twice weekly were documented on the record. Interview with the director of nursing (DON) on 3/1/07 at 7:35 AM confirmed that baths were not given as planned. b. Review of the facility's undated "Incontinence Protocol" (which included the "keep dry" program) showed staff were to check the resident's incontinence brief every two to three hours. Observation on 2/27/07 revealed staff failed to check the resident's brief from 7:30 AM until the observation ceased at 11:15 AM when the resident was eating lunch. Interview with certified nurse aide #9 on 2/27/07 at 12:46 PM verified the resident was not toileted during the aforementioned time period. 4. Review of the 6/7/06 annual and 2/21/07 quarterly MDS assessments revealed resident #27 had severely impaired cognition (never/rarely made decisions) and was totally dependent on staff for bathing. According to the 12/18/06 care plan the resident was to be bathed twice weekly. Review of the bathing records showed the resident did not receive two baths per week for the weeks of December 3rd, 17th, and 31st in 2006; January 21st in 2007; and February 18th in	F 282	Continued From page 8 conducted by the Clinical Supervisors and report findings to the QIC for further review and recommendations. 3/31/07	

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F 282	Continued From page 9 2007. No reasons for the missed baths were documented. Interview with the DON on 3/1/07 at 7:35 AM revealed the facility was aware baths were not being given as care planned. 5. Review of the 1/24/07 significant change and 10/26/06 quarterly MDS assessments showed resident #43 had moderate cognitive impairment and required extensive assistance from staff for bathing. Review of the 2/2/07 care plan showed staff were to assist the resident with bathing twice a week. Review of the bathing records revealed the resident did not receive two baths a week during the weeks of December 3rd, 10th, and 24th of 2006. According to the facility's documentation the resident was not bathed during the first week of January 2007 and received only one bath during the week of January 14th. No baths were documented as given during the weeks of February 4th and 25th, 2007. The only information related to the missed baths was documented as "Rescheduled" on 2/6/07; however, no bath was documented that week. Interview with the DON on 3/1/07 at 7:35 AM verified this resident was not bathed as planned. 6. According to the 6/13/06 admission and 2/21/07 quarterly MDS assessments, resident #93 was alert and oriented but required staff assistance with bathing. According to the 12/12/06 care plan, staff were to assist the resident with bathing twice weekly. Review of the bathing records showed the resident received one bath during the weeks of December 3rd, 11th, and 24th in 2006; January 28th in 2007; and February 4th in 2007. "Rescheduled" was written on the record for 12/12/06 and 12/13/06, but the resident did not receive two baths that week.	F 282		

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	536022	A. BUILDING _____ B. WING _____	03/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 6TH ST GILLETTE, WY 82716

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F 282	Continued From page 10 Furthermore, there was no documentation that the resident was bathed at any time during the first week of January, 2007. Interview with the DON on 3/1/07 at 7:35 AM confirmed baths were not always given twice a week as planned. The DON stated this was a problem they had not resolved.	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 resident and staff interview, the facility failed to adequately position one (#28) of eight sample residents who required staff assistance for repositioning. The findings were: Review of the significant change Minimum Data Set (MDS) assessment dated 1/17/07 revealed resident #26 required "extensive" staff assistance with bed mobility and was "totally dependent" on staff for transfers. The activities of daily living (ADL) care plan revealed that staff were to use a lift when moving the resident. Observation on 2/26/07 at 6 PM revealed the resident was in the Neighborhood 5 dining room seated in a reclining wheeled chair. The resident had slid down in the chair and his/her coccyx was at the end of the chair. Observation at that time revealed certified nursing assistant (CNA) #8	F 309	F309 The facility will ensure that 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: 1. Resident # 26 was evaluated by PT/OT to ensure that the appropriate seating arrangement is in place. CNA #8 was instructed on need to reposition this resident for safety reasons as well as resident comfort. 2. All residents who are dependent upon staff to reposition them could be impacted by this practice. The DON or designee with the assistance of physical therapy/occupational therapist will review all residents who are unable to reposition themselves to ensure that the best seating arrangements are in place. The SDC will conduct an in-service	~~3/31/07~~ 4/15/07

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F 308	Continued From page 11 raised the footrest and reclined the back of the chair, without repositioning the resident. The resident was transported to her room, and the CNA left without ever repositioning the resident. Observation on 2/27/07 from 2:15 PM to 3 PM and again on 2/28/07 from 3 PM to 3:30 PM showed the resident had slid down to the edge of the chair. Interview with the resident on 2/27/07 at 2:15 PM revealed s/he often felt like s/he was going to fall out of the chair. The resident stated when staff used the lift to transfer him/her to the chair, they did not position him/her back far enough to prevent sliding. Interview with CNAs #15 and #11 on 2/28/07 at 3:30 PM revealed that when the resident slides down in the chair, they should use the lift to reposition him/her.	F 309	Continued From page 11 training on positioning and transferring of residents. This will be conducted by 4/15/07. 3. A quality-monitoring tool will be implemented by DON and Clinical Supervisors to ensure that residents receive services in accordance with their comprehensive assessment and their plan of care. This monitoring will be completed weekly and presented to the DON or designee. 4. The DON or designee will report the findings of this quality-monitoring tool to the QIC for further review and recommendations. 3/31/07	
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 residents received care and services related to incontinence, continued use of urinary catheters, and care of urinary catheters. Two (#73, #65) of 10 sample residents who were incontinent were	F 315	F315 Based upon the resident's comprehensive assessment the facility will 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 will be accomplished by:	3/31/07

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F 315	Continued From page 12 not toileted and/or assisted according to care plan in order to maintain as much dryness as possible. One (#93) of three sample residents with urinary catheters lacked catheter care. In addition, the facility failed to assess the continued use of a urinary catheter for one (#62) of three sample residents with catheters. The findings were: 1. Medical record review for resident #65 revealed the resident's most recent quarterly Minimum Data Set (MDS) assessment dated 1/17/06 assessed the resident as totally incontinent of bladder. Review of the resident's most recent plan of care with a run date of 1/30/07 revealed the resident was incontinent and was on the facility's "keep dry" program. Review of the incontinence program revealed residents on the "keep dry" program used disposable briefs and required checking every two to three hours. Continuous observation on 2/26/07 from 1 PM until the 4:43 PM (3 hours and 43 minutes) revealed staff did not assist, cue, or check this resident for incontinence. Interview with the director of nursing (DON) on 2/28/07 at 4:48 PM revealed staff were expected to assist the resident according to his/her plan of care. Interview with two CNAs (#1, and #5) who assisted the resident on 2/26/07 at 4:45 PM verified that they were aware the resident was on the facility "keep dry" program and usually did not tell staff of his/her needs. 2. Observation on 2/27/07 at 5:30 PM revealed resident #62 had an indwelling catheter. Medical record review revealed the resident was admitted on 9/1/06 with an indwelling catheter. An interview on 3/1/07 at 9:00 AM with registered nurse (RN) #4 confirmed the resident had been admitted with a catheter. A bowel and bladder evaluation	F 315	Continued From page 12 1. Residents #65 and #73 had their plan of care reviewed for appropriateness of the toileting plan. CNAs were instructed on toileting residents before and after meals. Resident # 93 was assessed for a possible urinary tract infection due to poor handling of the catheter bag (Assessment of urine color, clarity and no symptoms of potential UTI was completed and foley was changed on 3/3/07 due to leakage. CNAs were counseled on proper technique of handling catheter bag; keeping it below bladder so urine cannot flow back into bladder. Resident # 52 had their Foley catheter reassessed, removed on 3/5/07 and a bowel and bladder assessment completed on 3/5/07. 2. All residents who need to be toileted or have a Foley catheter could be impacted by this practice. All residents with Foley catheters have been reviewed to ensure that appropriate diagnoses accompany the use of the catheter or the catheter and a bowel and bladder assessment has been completed to determine their continency status and toileting plan if applicable. 3. The DON or designee have in-serviced nursing staff on the	

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F 315	Continued From page 13 completed when the resident was admitted identified the resident as a potential candidate for a toileting program. However, a comprehensive assessment for the use of the catheter was not done. Further record review revealed that since the resident's admission on 9/1/06 there had been no attempt to discontinue the use of the catheter. Interview with the director of nursing (DON) on 3/1/07 at 8:30 AM revealed her expectation for residents admitted with catheters was to remove them "as soon as possible." The DON stated that residents with catheters were to be assessed upon admission in order to determine why the catheter was being used. The DON also stated that residents with catheters should be periodically reassessed. Interview on 3/1/07 at 10:30 AM the DON stated there was no other information available as to why the catheter was being used. 3. Review of the 12/13/06 Minimum Data Assessment (MDS) assessment revealed resident #73 had moderately impaired cognition (requiring cues and supervision) and was "totally dependent" on staff for assistance with toileting. Review of the 12/22/06 care plan showed the resident was on the "keep dry" program. According to the facility's information that described the program, staff were to check the resident's incontinence brief every two to three hours. Observation on 2/27/07, however, revealed staff failed to check the resident's brief from 7:30 AM until observations ceased at 11:15 AM. Interview with certified nurse aide (CNA) #9 on 2/27/07 at 12:46 PM confirmed she was caring for the resident that day. The CNA verified the resident was not toileted during the aforementioned time period. The CNA stated the resident was not toileted until she changed the	F 315	Continued From page 13 importance of following toileting plans, the "keep dry" program and how to properly position a catheter bag when moving a resident. Clinical supervisors will monitor compliance of nursing staff weekly by completing a monitoring tool. Clinical supervisors will review any resident admitted with a Foley catheter for appropriate diagnoses and either obtain written diagnoses and order for one from the physician or remove the catheter and implement a bowel and bladder assessment. 4. The DON or designee will review the weekly monitoring tools completed by the clinical supervisors and present findings to the QIC for further review and recommendations. 3/31/07	

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F 315	Continued From page 14 resident's wet incontinence brief at 12:40 PM. The CNA stated she was "just not able to get to" the resident. 4. Observation on 2/27/07 at 9 AM showed resident #93 had an indwelling urinary catheter. The overnight catheter bag was observed to contain approximately 1/4 of its capacity as dark amber urine. While assisting the resident to dress and transferring him/her per mechanical lift into a wheelchair, observation showed CNA #9 and nursing assistant #2 each lifted the catheter bag above the level of the resident's bladder; urine ran back up the tubing into the indwelling catheter. Review of laboratory results showed the resident had a previous urinary tract infection on 11/29/06. During an interview on 3/1/07 at 7:35 AM, the DON stated catheter bags should always be kept below the level of the resident's bladder.	F 315		
F 327 SS=D	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure hydration measures for three (#110, #27, #65) of 10 sample resident who required staff cueing and/or assistance to drink fluids. The findings were: 1. Observation of resident #110 on 2/28/07 at 12:57 PM revealed the resident was in his/her room with no fluids available and an empty cup on the sink. The observation revealed the	F 327	F327 The facility will ensure that each resident is provided with sufficient fluid intake to maintain proper hydration and health. This will be accomplished by:	3/31/07

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F 327	Continued From page 15 resident's roommate had a cup of water on his/her bedside table. At 2:18 PM staff entered the room and provided the resident with incontinence care. Then, without offering fluids, left the room. At 3:49 PM, staff once more entered the room, provided incontinence care and grooming, and assisted the resident up to a reclining wheeled chair. At 4:02 PM, staff wheeled the resident into the Neighborhood 5 dining area and placed a glass of milk within the resident's reach. In eight minutes, the resident had consumed the milk. Interview with licensed practical nurse #10 on 2/28/07 at 4:37 PM revealed there was no reason for the resident not to have fluids at the bedside. Review of the resident's most recent quarterly Minimum Data Set assessment dated 2/7/07 showed the resident required extensive assistance with eating. Review of the resident's care plan, with a run date of 2/16/07, revealed the resident could manage a cup and required cueing. The care plan did not include any rationale for keeping fluids out of the resident's reach. 2. Review of the 2/21/07 quarterly Minimum Data Set (MDS) assessment showed resident #27 had "severe cognitive impairment" and was "totally dependent" on staff for meal assistance. According to the nutrition assessment completed on 8/19/06 for the annual MDS assessment, the resident required 2,220 milliliters (more than 2 quarts) of fluid per day. Review of the 12/19/06 care plan revealed staff were to "push fluids," but an amount was not specified. Observation showed the resident's evening meal was served at 5:23 PM on 2/26/07. At 5:43 PM licensed practical nurse (LPN) #3 attempted to give the resident a bite of food. The resident refused to eat, so the LPN tried to give the resident milk and	F 327	Continued From page 15 1. Residents # 110, 27 and 65 were assessed for their hydration status 3/1/07. Staff was instructed on each of these resident's hydration needs. Sunshiners were provided a list of residents that need thicken fluids and instructed not to give fluids to residents on thickened liquids. Nursing staff was informed of this and that they will need to provide the thicken fluids for these residents. Fluids will be offered to residents every two hours while awake unless instructed otherwise. 2. All residents who are dependent on staff for obtaining fluids could be impacted by this practice. 3. Nursing staff were educated on the importance of providing fluids, which includes placing fluids where a resident can reach them, providing the correct consistency of fluids at least every two hours while awake or when requested and following the policy for documenting on residents' intake and output when ordered. Clinical supervisors will monitor residents' rooms for placement of water and correct consistency and to ensure that residents are offered fluids at least every two hours. The monitoring	

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F 327	Continued From page 16 juice. The resident consumed approximately 90 ml of fluid during that meal. Observation on 2/26/07 at 12:45 PM revealed the resident was sleeping. Further observation showed fluids were not positioned within reach of the resident, but were, instead, sitting on the counter by the sink. On that day at 3:15 PM, certified nurse aides (CNAs) #7, #8, and #17 were observed as they transferred the resident from a bed to a wheelchair. During that observation no one offered the resident anything to drink. Interview with CNA #7 upon completion of the transfer revealed the resident was unable to drink independently, required a straw, and was dependent on staff to offer fluids. At 3:22 PM CNA #7 obtained a straw, but left to get another lid. She returned at 3:26 PM, put the lid on the cup, placed the cup on the bed, and left the room without ever actually offering the resident a drink. At 3:50 PM CNA #7 stated staff were supposed to "push fluids," but she was unaware of a specific amount. The CNA stated that she should have offered fluids at 3:26 PM, but did not. The CNA reiterated the resident was totally dependent on staff for fluids. Interview with LPN #3 on 2/26/07 at 4:20 PM revealed the facility did not monitor the resident's fluid consumption. 3. Medical record review for resident #65 revealed an admission Resident Assessment Instrument dated 10/18/06 which showed the resident triggered for dehydration and required additional assessment. Review of the Resident Assessment Protocol (RAP) narrative report for dehydration dated 10/18/06 documented the resident had aspiration pneumonia while in the hospital, was unable to make his/her needs known, and required assistance with fluids. Review of the RAP narrative report for nutrition	F 327	Continued From page 16 will occur weekly and be presented to the DON for review. 4. The DON or designee will present the findings of the monitor to the QIC for further review and recommendations. 3/31/07	

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F 327	Continued From page 17 revealed the resident required "nectar" thickened liquids. A nutritional progress noted dated 1/17/07 at 3 PM documented that the resident's weight was up and down from admission. The writer further documented the weight fluctuations may be contributed to fluid changes and Lasix (a medication used to remove excess fluid). Review of the resident's medical record revealed a plan of care, with a run date of 1/30/07, showed the resident required assistance with intake and should receive "nectar thick" liquids. Further record review revealed a care plan for potential for dehydration. One of the interventions listed was "encourage fluid intake between 1000 and 1500 ml (milliliters) per 24 hours." The following concerns were noted: Interview with licensed practical nurse #10 and the Neighborhood 5 unit secretary #6 on 2/28/07 at 4:28 PM revealed the intake for resident #65 was not monitored or measured. Observation on 2/28/07 between 1 PM and 3:20 PM revealed resident #65 was seated at the Neighborhood 5 nurses' station without any fluids. Observation at 3:20 PM showed a staff member transported the resident into the Neighborhood 5 dining room and gave the resident a mug of water. Observation from 3:20 PM until the surveyor intervened at 4:43 PM, revealed the resident took one sip of the water. During the observation period, the resident was not assisted or cued to drink.	F 327		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F332 The facility will ensure that the medication error rate falls below the 5% ranking. This will be accomplished by:	3/31/07

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F 332	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to document medications were administered in accordance with physician's orders. The findings were: Review of the February 2007 Medical Administration Records (MARs) for 2 (#114, #26) of 20 sample residents revealed nursing staff failed to document whether various medications were administered, held or refused. Dates and times for the omitted medications as follows: 1. The February 2007 MAR for resident #114 had the following blanks: a. Aricept 10 mg one tablet a day: 2/11/07 at 8 PM. b. Namenda 10 mg one tablet twice a day: 2/20/07 at 8 PM, 2/22/07 at 8 PM, 2/26/07 at 8 PM. c. Atenolol 50 mg one tablet twice a day: 2/11/07 at 8 AM. d. Furosemide 40 mg one tablet twice a day: 2/11 AM. e. Lexapro 20 mg one tablet a day: 2/11/07 at 8 AM. f. Potassium chloride 10 meq twice a day: 2/7/07 at 8 AM, 2/11/07 at 8 AM, 2/13/07 at 8 PM, 2/5/07 at 8 AM, 2/20/07 at 8 AM, 2/22/07 at 8 AM, 2/26/07 at 8 PM. g. Synthyroid 100 mcg one tablet a day: 2/20/07 at 8 AM, 2/22/0 at 8 AM, 2/24/07 at 8 AM. h. Provigil 50 mg once a day: 2/10/07 at 8 AM, 2/11/07 at 8 AM. i. Invega 2 mg once a day: 2/11/07 at 8 AM. 2. The February 2007 MAR for resident #26 had the following blanks:	F 332	Continued From page 18 1. Residents # 114 and # 26; Their primary care physicians were notified of the possibly missed medications due to the inconsistencies in the documentation on the Medication Administration Records (MAR) in February 2007 and any, if at all, new orders because of the omissions. 2. All residents who have omissions of documentation on their MAR could be impacted by this practice. All of February MARs were reviewed and physicians notified as applicable. 3. Specific nurses that did not document were in-serviced on documenting on medications on 3/9/07. Nurses have been instructed to check the MARs at the end of each shift to ensure all medications given have been documented on. Clinical supervisors will check the MARS weekly to ensure compliance is met. When compliance is not met, individual nurses will receive additional training with documentation placed in the personnel file. 4. The DON or designee will check the weekly monitoring and present the	

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F 332	Continued From page 19 a. aspirin 1 tablet daily: 2/9/07. b. The 8 AM doses of benzotropine 1 mg on 2/6/07 and 2/25/07. c. The 8 AM doses of Bumex 4 mg on 2/6/07 and 2/25/07. d. The 8 AM doses of carbidopa/levodopa 25/100 mg on 2/6/07, 2/7/07, 2/14/07, 2/15/07, 2/22/07 and 2/25/07. e. Two 8 AM doses of cephalexin 500 mg on: 2/6/07 and 2/25/07 and an 8 PM dose on 2/23/07. f. The 8 AM doses of docusate, one capsule on 2/6/07 and 2/25/07. g. One dose of hydrochlorothiazide 25 mg on 2/6/07. h. Miralax 17 grams once a day 2/6/07 at 8 AM i. 8 AM doses of KlorCon 1.5 milligrams on: 2/6/07, 2/7/07, 2/14/07, 2/25/07 j. One 8 AM dose of Lamictal 100 mg on 2/6/07. k. Ranitidine 150 mg: 2/6/07 at 8 AM and 2/23/07 at 8 PM. l. Seroquel 300 mg: 2/6/07 at 8 AM, 2/23/07 at 8 PM. m. Spironaldactone 25 mg two tablets once a day: 2/6/07 at 8 AM. n. Lactolose one tablespoon once a day: 2/6/07 at 8 AM. Interview regarding the blanks on the MAR with LPN #18 on 2/28/07 at 4:30 PM revealed that if the documentation omission happened on her shift, she "administered the medication, but probably forgot to initial the MAR." Interview with the Director of Nursing (DON) on 3/1/07 at 8:28 AM revealed the omission of nursing initials on the MAR was inappropriate and nurses are taught that if the record was not initialed, the medication was not given According to Nursing "Interventions and Clinical	F 332	Continued From page 19 findings to the QIC for further review and recommendations. 3/31/07	

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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 ______	03/01/2007

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 332	Continued From page 20 Skills" second edition, copyright 2000, post medication administration activities include immediately recording the drug name, dose, route, time, and signature of the person who administered to the drug. The authors further state the act of documentation is particularly important when giving drugs ordered "prn" [as needed medication]. The significance of accurate documentation is further explained in "Nursing Malpractice: Sidestepping Legal Minefields," copyright 2003. This author explains the medical record provides legal proof of the nature and quality of care the patient received. The author states, "Healthcare professionals have a legal duty to maintain the medical record in sufficient detail." The author further explains inadequate documentation of care may result in liability or non-reimbursement by third-party payers.	F 332		
F 360 SS=D	483.35 DIETARY SERVICES The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to provide palatable meals for 1 non-sample (#40) and 2 of 7 sample (#27, #65) residents who required assistance with dining. The findings were: 1. According to the 2/21/07 quarterly Minimum Data Set (MDS) assessment, resident #27 had "severe" cognitive impairment and was "totally dependent" on staff for meal assistance.	F 360	F360 The facility will ensure that each residenst is provided with a nourishing, palatable, well balanced diet that meets the daily nutritional and special dietary needs of each resident. This will be accommplished by: 1. Residents # 40, # 27 and # 65; Staff were in-serviced on providing residents with food at correct temperature. If resident is not ready to eat food should be covered and placed in refrigerator until ready. Then at that time hot food will be heated prior to serving resident.	4/1/07

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F 360	Continued From page 21 Observation on 2/26/07 revealed the resident was asleep at the time his/her evening meal was served. The first attempt to assist this resident did not occur until 6:43 PM, 20 minutes after the meal was placed in front of the resident. Staff did not check the temperature of the food to ensure it remained palatable dispite the fact that it had been uncovered and open to room air for 20 minutes prior to initial attempts to get the resident to eat. No meal assistance or cueing was provided until 6:50 PM, a full 16 minutes later. As with the previous observation, the staff member (unidentified) who assisted the resident made no effort to ensure the food offered was at a palatable temperature prior to attempting to get the resident to eat. 2. Observation of resident #40 on 2/27/07 at 7:35 AM revealed the resident was sitting up in bed eating breakfast. The meal consisted of a fried egg, bacon, toast, pears, cooked cereal, milk, and juice. CNAs #12 and #16 entered the room with a mechanical lift and told the resident they would transfer him/her to a chair for breakfast. At 7:45 AM the transfer was completed and the meal was again placed in front of the resident. The CNAs exited the room. The resident commented as s/he began to eat that the breakfast was "getting cold." The resident also stated s/he would have preferred to finish the meal prior to the transfer. Observation of the transfer ha shown staff did not offer the resident the option of finishing his/her meal first. In addition, during the interview the resident stated she had not been offered the option of having the transfer prior to his/her breakfast being served. 3. Review of resident #65's quarterly MDS assessment showed the resident required	F 360	Continued From page 21 Staff was instructed on the need to assist residents who are dependent or monitor and offer queing when residents are independent, but slow to eat. 2. All residents who require assistance with meals could be impacted by this practice. 3. A meal serving order has been posted by the dietary supervisor to communicate to all staff when room trays will be dished. The dietary supervisor will work with dietary aides and nursing staff to improve communication to adjust serving times and order to meet the needs of individual residents to provide prompt meal service and assistance. Nursing will receive education on food safety and palatability in regard to food temperatures 4/1/07. The dishing, delivering and service of room trays will be monitored for one week to establish appropriate and feasible timeline guidelines 3/9/07. The room tray policy will be updated with specific time line guidelines by DM. Clinical supervisors will monitor the effectiveness of the new policy each week and present their findings to the DON.	

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F 360	Continued From page 22 "extensive assistance" with meals. Observation on 2/26/07 at 5:23 PM revealed the resident's evening meal had just been served, but the resident was not eating. CNA #7 sat down at the table across from the resident at 5:39 PM, but did not speak to, cue, or otherwise attempt to assist the resident. No other staff was observed to cue or assist the resident until 6:44 PM when LPN #3 assisted the resident. The LPN did not check the temperature of the food for palatability despite the fact that 21 minutes had elapsed from the time the uncovered food was placed in front of the resident. Interview with the Director of Nursing (DON) on 2/28/07 at 12:52 PM revealed the expectation was that staff would begin assisting any resident who required help with eating at the time his or her meal was served.	F 360	Continued From page 22 1. The DON or designee will present the findings to the QIC for further review and recommendations. 4/1/07	
F 370 SS=D	483.35(i)(1) SANITARY CONDITIONS - FOOD PROCUREMENT The facility must procure food from sources approved or considered satisfactory by Federal, State, or local authorities. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview and review of facility policy and procedure, the facility failed to ensure food served to four (#3, #36, #61, #112) non sample residents was from an approved source. The findings were: Observation in the main dining room on 2/26/07 at 5:20 PM revealed residents #3, #36, #61, and #112 served themselves soup from a ceramic	F 370	F 370 The facility will ensure that all food will be procured from sources that are approved or considered satisfactory by Federal, State or local authorities. This will be accomplished by: 1. The daughter of resident # 112 who stated she brought food from home and shared with residents # 3, 36, 61 and 112 was informed by Nutrition Services that she may no longer bring home prepared food in for any resident other than her family member (#112). 2/26/07 2. Any resident with family members who bring home-prepared food into the facility could impact other residents. The Pioneer Manor Family Newsletter, dated March 2007 explained that families may not share "home prepared" food with residents other than their own family member. 3. A special insert regarding dietary services will be developed to include in the admission packet. This insert will include information on the dangers of sharing "home prepared"	4/15/07

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	530022	A. BUILDING _____ B. WING _____	03/01/2007

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PIONEER MANOR NURSING HOME	800 W 8TH ST GILLETTE, WY 82716

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F 370	Continued From page 23 crack located in the center of the table. At 5:35 PM the daughter of resident #112 revealed she brought in home cooked soups about twice weekly for her family member and his/her table mates. She stated she had been bringing in homemade foods for most of the winter (approximately 3 months). Interview with the dietary manager on 2/28/07 at 5:45 PM revealed she was unaware of this practice. She then revealed there was a facility policy regarding outside food. Review of the policy titled "Approved Food" dated 9/29/05 showed "All food prepared for residents...by Nutrition Services will be purchased from an approved vendor." However, the procedures went on to say, "...employees will not be held liable for the condition of food brought in by families. None of this food may be reheated in the kitchen." According to Food Code 2005, U.S. Public Health Service, definitions and 3-201.11: (B) FOOD prepared in a private home may not be used or offered for human consumption in a FOOD ESTABLISHMENT. "Food establishment" means an operation that stores, prepares, packages, serves, vends or otherwise provides FOOD for human consumption."	F 370	Continued From page 23 food with residents other than family. It will also include food safety guidelines and instructions for families, to notify nursing and dietary when they intend to bring food for their family member. As appropriate a private dining area will be provided for families bringing in food for their family member. The current policy on approved food will be updated to include specific information on home prepared food for residents. Dietary will document in supervisor's report what food has been brought in for a resident. The revised policy will be shared with staff at the April 13th All Employee meeting. Staff will be advised to inform a dietary or nursing supervisor if they observe violation of the policy and the supervisor will correct the situation. Any violation of the policy will be noted in the daily dietary supervisor report and reported to administration as part of ongoing quality assurance. 4. The dietary supervisor report will be presented to the QIC for further review and recommendations. 4/15/07	
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		

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	536022	A. BUILDING _____ B. WING _____	03/01/2007

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F 425	Continued From page 24 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure expired medications were not available for administration to residents on two of five residential units. The findings were: 1. Observation of the Neighborhood 5 medication room with registered nurse (RN) #4 on 3/1/07 at 8:23 AM revealed 20 syringes locked in the narcotic cabinet. Each syringe was for resident #42 and was labeled "Opium Tincture" (a narcotic). All the syringes were labeled with an expiration date of 6/6/06. Interview with the RN at the time of the observation revealed the resident took the medication intermittently and verified that the medication was available for use. 2. On 3/1/07 at 8:45 AM, observation of the medication cart on neighborhood 3 with LPN #22 revealed two stock bottles of expired cough medications. An 8 ounce bottle of Tussin expired 8/06, and a 4 ounce bottle of Guaifenesin expired 11/06. At the time of the observation, the LPN verified the medications were available to use for residents.	F 425	F425 The facility will ensure the provision of routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.75(h) of this part. This will be accommplished by: 1. All medications that were expired were removed and disposed of per facility and Pharmaceutical services policy . 2. All medications were examined to ensure that no medication that had expired would be given to a resident prior to proper disposal. 3. The pharmacy has been instructed to place labels on medications that do not obstruct the expiration date on 3/1/07. The DON or designee will monitor medications weekly to ensure that compliance is met. 4. The DON or designee will present findings to the QIC for further review and recommendations. 3/31/07	3/31/07
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES	F 431		

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F 431	Continued From page 25 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure medications on two of three residential units were labeled in accordance	F 431	F 431 The facility will ensure that it employs the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This will be accomplished by: 1. All medications that were expired were removed and disposed of per facility and Pharmaceutical services policy . 2. All medications were examined to ensure that no medication that had expired would be given to a resident prior to proper disposal. 3. The pharmacy has been instructed to place labels on medications that do not obstruct the expiration date on 3/1/07. The DON or designee will monitor medications weekly to ensure that compliance is met. 4. The DON or designee will present findings to the QIC for further review and recommendations. 3/31/07	3/31/07

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F 431	Continued From page 26	F 431		

with accepted professional standards. The findings were:

1. The following concerns were observed on Neighborhood 5 on 3/1/07 at 8:23 AM:

a. The medication cart for hall B contained a bottle of promethazine/codeine syrup for resident #101; the label was dated 2/16/07. During the observation, licensed practical nurse (LPN) #25 stated she was unsure if the date was a "fill date or an expiration date," but she thought it was the date the medication had been filled. Further observation revealed a date clearly printed as the expiration date was not on the label.

b. The label on a bottle of Nasacort for resident #104 covered the expiration date. At the time of the observation LPN #25 stated the label was applied by the hospital pharmacy, and she verified the expiration date was covered.

c. The medication cart for hall A contained a bottle of promethazine/codeine for resident #55; however, the label lacked an expiration date. Registered nurse #4 confirmed the absence of an expiration date at the time of the observation.

2. The following concerns were observed on Neighborhood 5 on 3/1/07 at 8:45 AM:

a. The label on a bottle of Teargen for resident #8 covered the expiration date.

b. The label covered the expiration date on a bottle of Nasacort for resident #23.

c. The expiration date for a bottle of Teargen for resident #24 was covered by the label.

d. The label of a bottle of Teargen for Resident #64 covered the expiration date.

e. A bottle of Colace liquid for resident #87 lacked an expiration date.

Interview with LPN #22 at the time of the

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F 431	Continued From page 27 observations confirmed the absence of an expiration for the Colace and verified the other expiration dates were not visible.	F 431		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of policy and procedure, the facility failed to ensure staff practiced proper hand washing techniques during one random observation in the secure unit. The findings were: Observation on 2/27/07 at 8:56 AM revealed certified nursing aide (CNA) #19 handled the lid of the garbage can in order to deposit trash into the can. Then, without washing her hands, the CNA re-positioned two glasses filled with drinks for residents #94 and #97. She handled the glasses by the rim as she moved them closer to the residents. Both residents were observed to drink from the contaminated glasses. Interview with the director of nursing (DON) on 2/28/07 at 1:33 PM confirmed staff were to wash their hands after handling trash. Review of the facility's policy and procedure on handwashing, dated July 2005, showed hands must be washed before eating and whenever the hands are likely to be contaminated.	F 444	F 444 The facility will ensure that staff must be required to wash their hands after each direct resident contact for which hand washing is indicated by acceptable professional practice. This will be accomplished by: 1. The C.N.A. (#19) cited in the survey was counseled on proper hand-washing technique 2/28/07 2. All CNAs will be required to complete a hand-washing competency by 3/30/07 3. Infection Control in-services will be conducted by the SDC. SDC, Clinical Supervisors or designees will monitor nursing staff weekly for hadwashing compliance. 4. DON will present findings of monitoring to the QIC for further review and recommendations 4/1/07	4/1/07
F 464 SS=E	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed,	F 464		

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F 454	Continued From page 28 equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on two of two observations and staff interview, the facility failed to ensure the safety of residents, personnel and the public by improperly storing oxygen cylinders. The findings were: Observation on 2/26/07 at 4:22 PM and again on 2/28/07 at 4:48 PM revealed the oxygen storage room immediately adjacent to the ambulance entrance did not have any type of room ventilation in violation of the 2005 edition of NFPA 99 Section 4-3.1.1.2 (c), "Storage Requirements for Nonflammable Gases Less Than 3000 cubic feet." The room contained 43 full and 29 empty type "E" oxygen storage cylinders. Interview by conference call with the Plant Operations Manager on 2/28/07 at 3:15 PM revealed the room had been remodeled approximately two months prior to the survey. The room's function was changed from that of an office to an oxygen storage room. The manager stated the facility did not notify the Wyoming State Health Department of the functional change.	F 454	F454 The facility will ensure that all future construction/remodeling complies with the Department of Health Chapter III, Construction Rules for Health Facilities. This will be accomplished by: 1. The oxygen storage room, which did not have any type of room ventilation, at the time of the survey, was in violation of the 2005 edition of NFPA 99 Section 4-3.1.1.2(c), "Storage Requirements for Nonflammable Gases Less than 3000 cubic feet", has been retrofitted with ventilation which meets the requirement. The ventilation system will be upgraded to mechanical ventilation by September 28, 2007. A waiver is being submitted with the Life Safety Code (LSC) survey PoC. A copy of this waiver request will be forwarded to the office of Healthcare Licensing & Surveys upon completion and submission to the LSC survey agency. 2. From the time of the survey going forward all project plans involving construction or remodeling will be reviewed by the Administrator and the VP of Facilities Management and forwarded to the appropriate authorities at the Wyoming State Health Department for review. 9/28/07	~~9/28/07~~ See revised POC

F454 ***REVISED***

The facility will ensure that all future construction/remodeling complies with the Department of Health Chapter III, Construction Rules for Health Facilities. This will be accomplished by:

4/12/07

The facility will ensure that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. This will be accomplished by:

Standard not met as indicated by the following finding: 1.) The new oxygen storage room was not vented outside, but was vented into the attic.

Corrective Action for this Standard: All oxygen has been removed from this storage area and relocated outdoors on a temporary basis until the planned installation of a mechanical exhaust system can be presented to and approved by the State of Wyoming and installed according to NFPA code. Design of the mechanical ventilation system for the oxygen storage room is in process. A design package (Blue print) will be submitted to the WYDOH for approval and installation of the system as soon as the approvals are received.

The DON, administrator and VP of Facilities and Plant Operations will monitor to ensure that the temporary oxygen storage, both indoors and

Continued from previous page

Outdoors, complies with NFPA standards for oxygen storage. This will be monitored and reported to QA meetings until such time as the oxygen storage room is adequately ventilated and meets code requirements.