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

PRINTED: 08/23/2007
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
	536022	A. BUILDING _____ B. WING _____	C 08/08/2007

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 157 SS=F	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure physicians were immediately notified of situations which required, or had the potential to require, medical	F 157	F157 The facility will ensure that physician's are immediately notified of situations that require or have the potential to require intervention. This will be accomplished by: 1. Timeliness of physician notification or initiation of new or modified orders from the physician on ~~the following~~ Residents #26, #35, #45, #52, #68, #118 and #130 ~~and all future notifications to physicians~~ will be corrected as follows: a. If immediate action is required, nurse will call physician and discuss concerns and findings and obtain telephone order for treatment. If no order given, it will be documented on interim as telephone order. b. All orders received by nursing will be acted upon immediately. Change in policy and procedure occurred 8/20/07 ~~Dr. J. Naramore~~, Medical Director and ~~Deb Fong~~ Vice President of Patient Services reviewed the policy and procedure change. Clinical Supervisors initiated the change on 8/21/07 after reviewing with nursing staff. A reminder notice was placed at each nurse's station. On 8/30/07 policy was reviewed again at mandatory nurses meetings. c. Medical Staff was informed of policy change by letter from Medical Director on 8/27/07.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles K. Cooper — TITLE: Administrator — (X6) DATE: 8/30/07

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.

RECEIVED
SEP 04 2007
Wyoming Dept of Health
Licensing and Surveys

This POC accepted & all additions & corrections on 9/10/07 @ 1440 per phone call between Charles Julley, Adm. & Betty Nelson, Surveyor.

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F 157	Continued From page 1 intervention for 7 (#26, #35, #45, #62, #68, #118, #130) of 7 sample residents. The findings were: Interview with the unit secretary on 8/7/07 at 4:30 PM revealed the facility used a courier service to relay information/requests and interm orders to and from each resident's physician unless it was an urgent matter; if urgent, one of the nurses would call the physician for orders. The unit secretary stated that requested orders were not initiated until the physician signed and returned them to the facility. On 8/7/07 at 5:50 PM the administrator confirmed the physicians did not take faxed information or requests for orders and acknowledged that several days could elapse before requested interim orders were returned. The administrator also acknowledged that the delay could cause an unfortunate outcome. The following concerns were identified: a. According to laboratory results dated 7/26/07, resident #118 was positive for a urinary tract infection (UTI), and a culture and sensitivity (C&S) test was completed. A verbal order for the antibiotic, Macrobid twice daily for 7 days, was received that day and started on 7/26/07 at 6 PM. Review of the C&S results revealed this resident's infection was resistant to Macrobid and sensitive to the tetracyclines. Review of interim orders dated 7/30/07 showed the primary physician ordered Doxycycline (a tetracycline antibiotic) twice daily for 5 days. This order was noted on 8/1/07 at 2 PM, but was not stamped with a received date. The medical record also showed another interim order was sent to the primary physician, also dated 7/30/07, notifying him that the facility had received a previous order for Doxycycline and asking whether the physician wanted the order continued or discontinued because the resident was already on Macrobid.	F 157	Continued From Page 1 of 9 d. DON and Administrator discussed this with Department of Medicine on 8/28/07. e. Nursing leadership will monitor daily for compliance using QI monitoring tool that has been developed. a report to QIC. f. Completion date of 9/22/07. 2. Receiving orders: a. Courier continues to bring orders to facility. Upon receiving in facility, orders are stamped with receiving date and then reviewed by nursing leadership. b. On 8/28/07, DON and Administrator met with Department of Medicine to discuss immediate action on interims. Physicians discussed and agree that orders will be acted upon daily and sent back to the facility either by fax or courier. c. Nursing leadership will develop a monitoring tool for this process. The results of this monitoring tool will be presented to the QIC for further review and additional training as needed. d. Completion date of 9/22/07	9/22/07

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F 157	Continued From page 2 The physician's response was "Yes continue..." This interim order was stamped "RECEIVED AUG 02 2007" but was noted on 7/30/07. The facility was unable to explain these discrepancies. Review of the medication administration records with the unit secretary showed the resident received Macrobid as ordered from 7/28/07 but was not started on Doxycycline, an antibiotic to which the UTI was sensitive, until 8/2/07. The outcome of the courier method of communication was that the resident did not receive an appropriate antibiotic until 5 days after the infection was identified. b. Review of information dated 4/20/07 and couriered to the physician revealed resident #130 had 3+ edema in both lower legs. An order from the physician for a diuretic every morning for 2 weeks was received and noted by the facility on 4/24/07, four days after the physician was originally notified. c. Review of the medical record for resident #35 revealed the facility couriered information to the resident's physician on 5/8/07 and reported the resident complained of an "itching scalp. Please order treatment." The primary physician wrote an order on 5/11/07 (3 days after the request for treatment was sent) to "refer to Dermatologist." In addition, review of another physician notification sheet stamped as being sent by courier to the physician on 7/20/07 reported "Resident wants to go to physical therapy to exercise. Is this OK with you?" The physician's response was stamped as received by the facility four days later on 7/24/07 and stated "Yes." Physical therapy was not initiated until after 7/24/07. d. Review of medical records for residents #26, #45, #52, and #58 revealed all contained physician notification sheets couriered to their	F 157		

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F 157	Continued From page 3 physicians with information and/or requests for orders. The response time until orders were initiated varied from the day of the request until 6 days later.	F 157		
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 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced	F 272		

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F 272	Continued From page 4 by: Based on medical record review and staff interview, the facility failed to provide comprehensive bowel assessments for three (#26, #118, #130) of three sample residents who were assessed as incontinent of bowel. The findings were: 1. Review of the 5/21/07 admission Minimum Data Set (MDS) assessment revealed resident # 26 was incontinent of bowel two to three times a week and required a comprehensive assessment. Review of the only bowel assessment in the medical record showed it was done one day after admission and documented the resident was continent. However, review of the 5/6/07 to 5/12/07 MDS information gathering tool and the certified nurse aide (CNA) flow sheets for May 2007 showed the resident was incontinent of bowel. Interview with the MDS coordinator on 8/8/07 at 10:40 AM confirmed the resident had been incontinent of bowel since admission. She verified that a comprehensive bowel assessment was not completed for this resident. 2. According to the 2/12/07 admission MDS assessment, resident #118 was incontinent of bowel weekly and required a comprehensive assessment. Review of the entire medical record showed that assessment was lacking. Interview with the MDS coordinator on 8/8/07 at 11 AM verified a comprehensive bowel assessment was not completed. 3. Review of the 4/9/07 admission MDS assessment showed resident #130 was continent of bowel. However, according to the nursing notes, the resident developed diarrhea on 4/30/07 which lasted through May and June 2007. Further	F 272	F272 The facility will conduct initial, periodic and as necessary comprehensive bowel assessments. Accurate standardized assessments will be completed on each resident's functional capacity. This will be accomplished by: 1. Assessments for Resident's #26, #118 have been completed. Resident #130 has been discharged from the facility. Following is corrective action to ensure comprehensive assessments are completed on each resident: a. New bowel assessment form will be developed and education on form will be completed by nursing staff and initiated on all residents as indicated by b. An accurate standardized assessment will be completed for each resident on admission. c. A quality-monitoring tool will be implemented by nursing leadership and presented to the QIC for further review and recommendation. d. Completion date of 9/22/07.	9/22/07

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F 272	Continued From page 5 review of the medical record showed a comprehensive bowel assessment was not completed after the resident developed diarrhea. On 8/6/07 at 11:30 AM, the MDS coordinator confirmed a comprehensive bowel assessment had not been completed.	F 272	F364 The facility will provide each resident with palatable food at the proper temperature. This will be accomplished by: 1. Resident #26 and 2 unidentified, non-sample residents were not provided with palatable food at the right temperature during a meal observation. A. Dietary has been educated that no food will be served until resident is seated at their table. B. If resident is not seated or not ready to eat, food will be delayed in serving from steam table or if already served and resident is not ready to commence eating the food will be covered and placed in refrigerator until resident is ready. At that time, hot food will be heated before serving to the resident. C. Dietary will monitor food placed in refrigerator for time to be removed. If resident wants food after that time, dietary will be notified to serve up a fresh meal. D. Clinical Supervisors will monitor meal passes randomly and log results in the monitoring tool. E. DON will present the findings to the QIC for further review and recommendations. F. Completion date of 9/22/07	
F 364 SS=D	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide palatable food at the proper temperature for 1 sample (#26) and 2 unidentified, non-sample residents during one of one meal observations. The findings were: Observation of the evening meal on 8/7/06 at 5:30 PM revealed resident #26 and 2 other unidentified residents were seated at an assisted table. The meals, consisting of pureed or ground sausage and chopped French toast, were uncovered and were served at 5:30 PM. None of residents were assisted until 5:45 PM. The food remained uncovered during that time. No attempt to check the temperature of the food or reheat the food was made.	F 364		
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		9/22/07

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F 428	Continued From page 8 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the primary physician acted upon recommendations made by the licensed pharmacist during the monthly medication regimen review for one of one sample (#68) residents. The findings were: Review of the May 2007 medication regimen record for resident #68 revealed the pharmacist asked the physician to consider checking a cholesterol panel and liver function tests for this resident who was receiving Vytorin (a cholesterol lowering medication). In addition, the pharmacist asked the physician to consider a dose reduction of the Zoloft for this resident or provide a list of the risks verses benefits of continuing the drug at the current level. They physician had not indicated by initial or comment that he was aware of these recommendations. The June 2007 medication regimen review referred to the May 2007 record and documented: "Please see above." The July 2007 review documented: "No other concerns than those noted above." There was no indication in the record that the physician acted upon the pharmacist's recommendations for May, June or July 2007. Interview with the director of nursing on 8/8/07 at 2:45 PM verified the physician's lack of action related to the pharmacist's recommendations.	F 428	F428 The facility will ensure primary physicians act upon recommendations made by the licensed pharmacist during the monthly medication regimen review. This will be accomplished by: A. Resident #68; physician was informed by DON of his lack of action from Pharmacists' recommendation. B. A letter was sent to physician to inform him of his responsibility to review and sign off (act on) on recommendations of the Pharmacist. C. Medical Director was notified of noncompliance of physician on 8/24/07 at Medical Directors meeting. D. On 8/27/07, Medical Director sent letter to all facility physicians informing or reminding them of this requirement. E. Nursing leadership will develop a monitoring tool to ensure that compliance is met. F. DON will present findings to the QIC for further review and recommendations. G. Completion date of 9/22/07.	9/22/07

all residents including #68,

implement.

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F 441 SS=E	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, staff interview, and review of policies and procedures, the facility failed to ensure staff utilized all possible methods to prevent the transmission of diseases and infections in one of five residential units. The findings were: Observation on 8/7/07 at 1:30 PM showed four isolation carts were located outside in the corridor on Neighborhood 5 (N5). Interview with licensed practical nurse #1 on 8/7/07 at 1:57 PM revealed four of the residents who resided on N5 were infected with methicillin resistant Staphylococcus aureus (MRSA). Observation at 2:20 PM that day showed certified nurse aide (CNA) #2 passed ice to all residents, including the four with MRSA. The CNA put the ice scoop completely inside each resident's insulated drinking cup while filling it with ice. During the process, she touched the rim and/or sides of each cup with the scoop. This process contaminated the scoop. After filling each cup, the CNA put the scoop back into the container of ice, thus contaminating the ice, as	F 441	F441 The facility will ensure all staff will utilize all possible methods to prevent the transmission of diseases and infections. This will be accomplished by: A. On 8/17/07, Staff Development Coordinator and the DON in-serviced CNA's on proper "Serving of Drinking Water" and the facility policy was reviewed. Demonstration of proper technique was completed. B. On 8/30/07, the Staff Development Coordinator in-serviced nurses on proper "Serving of Drinking Water" and facility policy was reviewed. C. Nursing leadership will develop a monitoring tool to ensure that compliance is continually met. and implement D. DON will present findings to the QIC for further review and recommendations. E. Completion date of 9/22/07.	9/22/07

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F 441	Continued From page 8 well. On 8/7/07 at 3:30 PM the director of nursing designee stated the ice scoop was not to be placed inside the cups.	F 441		
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 and review of facility check off forms, staff failed to wash their hands as indicated by accepted professional practice. The findings were: Observation on 8/7/07 at 2:12 PM showed certified nurse aide (CNA) #2 washed her hands after providing care for resident #26. However, the CNA turned off the faucet with her wet hands before drying them on paper towels. The correct handwashing procedure, as described in the facility's undated policy entitled: "Washing Hands - Check Off" was to "Use clean, dry paper towel to dry hands...To turn off water, use dry clean paper towel or a dry area of paper towel." Further review of the procedure showed hand washing, "when done correctly, is the single most effective way to prevent the spread of communicable diseases."	F 444	F444 The facility will ensure that staff wash their hands as indicated by accepted professional practice that includes handling of faucet handles and doorknobs. This will be accomplished by: A. ~~CNA #2, cited in the survey, received additional training on proper professional practices on 8/7/07.~~ B. On 8/17/07, the Staff Development Coordinator and the DON in-serviced CNA's on professional practices of hand washing which in included proper handling of faucet handles and doorknobs. C. On 8/30/07, Staff Development Coordinator and the DON in-serviced professional nurses on proper practices of hand washing including, handling of faucet handles and doorknobs. D. Nursing leadership will develop and implement monitoring tool to ensure compliance of proper hand-washing procedure. E. DON will present findings to QIC for further review and recommendations. F. Completion date of 9/10/07.	9/10/07