STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	R-C 12/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

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{F 000}	INITIAL COMMENTS The following common abbreviations are used throughout this document: RN - registered nurse LPN - licensed practical nurse DON - director of nursing MDS - Minimum Data Set CNA - certified nurse aide ADL - activities of daily living Less commonly used abbreviations will be annotated in each deficiency where used.	{F 000}		
{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;	{F 272}		12/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Brown — TITLE: Board Chairman — (X6) DATE: 12/20/10

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 272}	Continued From page 1 Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to evaluate devices used by 2 of 3 sample residents (#4, #19) for safety, medical necessity, or as possible physical restraints. The findings were: Observation on 11/30/10 at 5:15 PM revealed side rails cited during the 10/19/10 survey had been removed and replaced with bolsters for residents #4 and #19. Review of the medical records for these residents failed to show any medical rationale for the bolsters or any assessments of the bolsters related to safety. Interview with the DON and RN #1 on 12/1/10 at 4:10 PM verified the failure to identify any medical conditions addressed by the use of the bolsters. They also confirmed the facility had not evaluated the bolsters as safe assistive devices for these residents.	{F 272}	The facility has met this requirement by conducting initial and periodic comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. MDS 3.0 training was provided in September 2010 and again in October 2010 for the MDS Coordinator. Resident # 4 and # 19 had a study completed by nursing staff on use of safety devices, appropriateness and rationale. The facility will maintain this requirement through a quality indicator that will be monitored monthly by IDT and reported to QA/QI committee.	
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	{F 280}		12/17/10

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{F 280}	Continued From page 2 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, family and staff interviews, and review of incident reports, the facility failed to revise the care plan for 1 of 6 sample residents (#10) in order to meet the resident's current needs. In addition, the facility failed to inform the resident's family of the resident's current status or to include the family's input in the care planning process. The findings were: According to the 10/30/10 quarterly MDS assessment, resident #10 displayed physical and verbal behavioral symptoms directed towards others and rejected care 4 to 6 days a week. These behaviors were defined as "hitting, kicking...grabbing, abusing others sexually," as well as threatening, screaming, cursing at others, and refusing medications and/or ADL assistance. Review of the nurses' notes and incident reports showed these behaviors had been occurring over the past several months. Review of the resident's behavioral care plan, last reviewed by the facility on 8/10/10, showed no revisions or specific	{F 280}	The facility has met this requirement as evidenced by all resident care plans have been reviewed and updated in a timely manner and as significant changes indicate. Care plan for resident #10, was revised and updated regarding dealing with behaviors, effective interventions and helping to reduce/eliminate inappropriate behaviors. Furthermore, all resident care plans have been reviewed and updated by IDT to ensure accuracy and appropriateness. Nursing staff will update all care plans to reflect any changes made, including discontinuing use of items or new orders/interventions to be initiated. A quality indicator has been developed and will be monitored by IDT through	

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{F 280}	Continued From page 3 interventions had been developed that addressed reducing or eliminating the resident's behaviors. Furthermore, the care plan showed no revisions in the goals or interventions Interviews with family members on 12/1/10 at 12 PM and 2:08 PM revealed they had not been notified of the resident's behaviors and had not been involved in revising the care plan. They stated they were unable to attend the last two care conferences due to physical limitations, but the facility made no attempt to reschedule the meeting or have the family members attend per telephone conference. On 12/1/10 at 3:10 PM the social worker stated the family had not been informed of the resident's behaviors as they were directed towards staff. She confirmed the family had not been present at the last two care conferences and that the care plan had not been revised.	{F 280}	QA/QI program.	
{F 281} SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interviews, and review of policies and procedures, the facility failed to ensure staff followed professional standards of practice related to medication administration for 1 of 4 residents (#12). In addition, 1 of 2 medication passes was not completed in a timely manner. The findings were: 1. Observation on 12/1/10 showed LPN #8 prepared morning medications for resident #12	{F 281}	The facility has met this requirement as evidenced by resident #12 having Synthroid administered on an empty stomach as directed to ensure intended therapeutic effect. All nurses will be inserviced on safe medication practices, the six rights. Medications will be administered correctly to all residents. Each resident, requiring pill a cutter will be provided individual pill cutters, to	12/20/10

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{F 281}	Continued From page 4 after the resident had eaten breakfast. Even though the label on the unit dose package instructed that Synthroid should be taken on an empty stomach, it was included with the other medications. At 9:11 AM, after preparing the medications, interview with the LPN revealed she was unaware of the instructions on the front of the package. She stated Synthroid was always given with the 8 AM medications. Review of the package and the medication administration records showed the resident received five doses from that specific package. At 9:15 AM that morning, the resident confirmed s/he routinely received Synthroid with the rest of the morning medications. According to Smith, Duell, Martin in "Clinical Nursing Skills Basic to Advanced Skills" Seventh Edition, 2008 ; page 569: "The Six Rights" of medication administration include giving the medication the right time. 2. Observation on 12/1/10 at 9:11 AM during preparation of the medications showed the LPN had to cut a pill in half to obtain the correct dosage of a medication. However, the pill cutter had white powder in all corners and on the blade that the LPN did not remove until after completing the task. At that time she confirmed the pill cutter was not clean when she used it. 3. Observation at 10:15 AM showed LPN #8 was closing the medication cart. At that time the LPN stated she had just completed administering the last of the medications scheduled for 8 AM . She confirmed this exceeded the allowed timeline of one hour before or after the routinely scheduled time. According to Smith, Duell, Martin B in "Clinical Nursing Skills Basic to Advanced Skills" Seventh Edition, 2008, page 569: "The Six Rights" of medication administration include	{F 281}	prevent cross contamination. To ensure timely medication pass, colored dots were applied to all medication bottles to correspond with times on the medication record. In addition, two nurses will be responsible for the am medication pass to ensure timely pass. This requirement will be maintained weekly by observing and reviewing medication passes and monitored by Treatment Nurse under direction of DON through QA/QI program.	

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{F 281}	Continued From page 5 giving medication at the right time. For medication administration in long term care, the right time is defined as one hour before or after the scheduled time.	{F 281}		
{F 309} SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to evaluate pain for 1 of 4 sample residents (#18) who were identified as having pain. This failure resulted in avoidable pain for resident #18. The findings were: According to the medical record face sheet, resident #18 was admitted to the facility on 4/22/10 with diagnoses that included osteoarthritis and osteoporosis. Review of the 10/27/10 quarterly MDS assessment showed the resident was unable to speak and unable to make him/herself understood. The MDS documented indicators of pain for this resident that were observed 3-4 days during a 5 day period. These indicators included non-verbal sounds, facial expressions, and protective body movements or postures. Review of the 10/26/10 quarterly nurses' note showed the resident received Tylenol elixir 500 mg daily for pain control.	{F 309}	The facility has met this requirement as evidenced by resident #18 being evaluated and had pain assessment completed to minimize pain. Each resident will receive the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #18 was evaluated by physician and medication was adjusted. Effectiveness of all pain medication will be documented on Pain Assessment Form located with the MAR. Assessment and findings will be incorporated into the care plan and will include resident specific interventions.	12/17/10

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{F 309}	Continued From page 6 However, the note documented that the resident's pain could not be assessed, and the effect of the pain medication could not be determined. Further review of the record failed to show an evaluation of staff- identified pain indicators or any plan to address the signs and symptoms of pain. The resident was cited on the previous survey dated 10/19/10 for this same issue. The following concerns were identified: a. During an observation on 12/01/10 at 7:15 AM CNAs #3 and #9 were assisting the resident to the bathroom with a mechanical lift. As the resident was maneuvered and coached by the CNAs to hold onto the lift, the resident displayed facial grimacing. b. Review of an untimed 10/27/10 late entry nursing note showed the "...resident continued to be tearful and was resistant to move limbs when testing range of movement [ROM], as if they were stiff." The nurse communication to the physician dated 10/27/10 showed..."resident continues to be tearful and cry often, could this be from pain, depression, or part of the disease process?" Detailed review of the medical record showed no response from the physician related to this communication. Interview with RN #1 on 12/1/10 at 2:30 PM confirmed the physician had not responded to the 10/27/10 communication. The RN produced some orders received since then, including one dated 11/9/10 for an evaluation of the resident's range of motion (ROM). She verified there were no orders related to pain relief. Review of the ROM evaluation showed it was completed on 11/15/10. However, the evaluation failed to address the resident's pain with movement. According to documentation in the record dated 11/18/10, the resident continued to display indicators of pain. Review of an un-timed nurses	{F 309}	The MDS/care plan will be reviewed upon completion at weekly interdisciplinary care plan meetings. The MDS Coordinator and the IDT data has been recorded. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	

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{F 309}	Continued From page 7 note on this date showed the resident was up and "grimaced as if in pain." Interview with the DON on 12/1/10 at 11:59 AM revealed she was unable to find any follow-up after this note that addressed the issue of pain.	{F 309}		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure 1 of 1 sample residents (#18) transferred with a mechanical lift was capable of completing the transfer safely. The findings were: During an observation on 12/01/10 at 7:15 AM, CNAs #3 and #9 were assisting resident #18 to the bathroom with a sit-to-stand mechanical lift. In order to stand, the resident was required to hold onto the lift without the use of security devices. During the transfer, the resident made facial grimaces, and resident's wide open eyes gave the appearance of fear while s/he held onto the lift with out-stretched arms. Review of the 11/15/10 physical therapy range of motion evaluation showed the use of mechanical lifts were not addressed. The evaluation documented that the resident required the assistance of two staff for transfers and bed mobility. Further review of the	F 323	The facility has met this requirement as evidenced by resident #18 has been evaluated by the physician. The physician assessed resident for appropriate use of sit to stand lift for safe transfers. Each resident will be evaluated, by the IDT, on admission, quarterly and upon significant change, for appropriateness of safety devices. Assessment and finding will be incorporated into the care plan and will include resident specific interventions. A quality indicator has been developed and will be monitored by IDT monthly through QA/QI program.	12/17/10

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F 323	Continued From page 8 medial record failed to show the mechanical lift was determined to be a safe method of transfer for this resident.	F 323		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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.	{F 431}		12/14/10

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{F 431}	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expiration dates were included on labels of medication bottles for 2 of 5 residents (#23, #24) whose medications were reviewed. The findings were: Observation on 12/1/10 at 7:58 AM revealed medications for resident #24 were prepared by LPN #8. Review of six medication bottles showed none of the labels contained an expiration date. At that time the LPN confirmed the absence of expiration dates. She stated not all of the pharmacies included those dates on the labels of medications they dispensed. On 12/2/10 at 7:59 AM LPN #8 was observed preparing Sertraline 25 milligrams for resident #23. This prescription had been filled by a different pharmacy, and the label did not have an expiration date.	{F 431}	The facility has met this requirement by all resident medication bottles having an expiration date. No medication will be accepted from pharmacy without expiration dates. Nurses oriented on this procedure. Nursing staff and pharmacists have been in-serviced on CMS regulations for expiration dates on medication labels. This requirement will be maintained by implementation of Medication Receiving Form. No medication will be accepted without expiration date and complete label requirements, this is completed at time of medication check-in. A quality indicator has been developed and will be monitored by DON through QA/QI program.	
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	{F 441}		12/9/10

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{F 441}	Continued From page 10 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of infection control policies users' instructions for a glucose testing device (glucometer), and review of a competency checklist for licensed staff, the facility failed to ensure nursing staff understood and complied with critical infection control steps in the use of a glucometer during 1 of 1 random observations of glucose testing. The findings were: On 12/1/10 at 7:40 AM, RN #6 was observed performing a finger-stick blood glucose test on	{F 441}	The facility has met this requirement by in-servicing and training all staff associated with LTC on proper infection control procedures and cleaning guidelines. Furthermore individual glucometers have been provided per resident requiring glucose monitoring, to reduce potential for infection. This requirement will be monitored	

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{F 441}	Continued From page 11 resident #5. Upon completion of the testing sequence, the RN returned the glucometer to its case, placed the case into a basket with other supplies, and put the basket in a cabinet on the medication cart. The RN did not wipe, clean, or disinfect the glucometer before or after using it on the resident. In an interview at 7:50 AM the same morning, the RN stated that in the eight days she had worked at the facility, "I never do that [clean the glucometer after use]...never done that anywhere I have ever worked." The nurse acknowledged she did not know if the manufacturer required cleaning and disinfecting the glucometer after use, nor did she know whether or not the facility had policies and procedures for using point-of-care devices such as the glucometer. The RN further stated she did not remember being told about glucometer cleaning during her orientation at the nursing home. Review of the 11/19/10 "RN/LPN Competency Checklist" for the RN showed she was determined by the DON to be competent in specimen collection and limited laboratory skills, as well as the ability to "...verbalize and locate appropriate policy and procedure manuals (LTC, infection control, disaster)." The DON stated in interview on 12/2/10 at 10:20 AM that she had evaluated the RN's skills and determined her to be competent. Interview with the infection control nurse on 12/1/10 at 8:25 AM revealed the facility's infection control policies required glucometers be cleaned with a product approved by the manufacturer of the device after each use and "...especially before using it on another person..." Review of the manufacturer's instruction manual for the glucometer (Abbott Optium Blood Glucose Monitoring System) showed a warning	{F 441}	monthly by nursing staff and DON with a quality indicator and will be reported to the QA/QI program.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 12 statement on page 3 identifying improper cleaning of the glucometer as a potential infection risk and requiring users to follow the infection control policies and procedures of their facility.	{F 441}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the quality assurance (QA) program information, staff interview, medical record review, and observation, the facility failed to fully implement an effective QA program with	{F 520}	The facility has met this requirement by the DON, a physician and three other LTC staff members attending quarterly QA/QI meetings. If the medical director	12/15/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	R-C 12/02/2010

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CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

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{F 520}	Continued From page 13 action plans to correct previously identified deficiencies. The findings were: Interview with RN #7 and medical records staff member #2 revealed the QA program lacked a coordinator. The medical records staff member stated she was "filling in" and was responsible to input the monthly data into the computer. She did not consider herself as overseeing or coordinating the program. During the 10 /19/10 revisit survey, the QA program was identified as deficient. Although data had been collected since September 2010, the action plans were not evaluated by the quality committee to ensure their effectiveness in resolving issues or sustaining improvement. Review of the QA worksheets for 2010 showed multiple monitoring results below 90%, the minimum baseline selected by the facility for successful performance. In the case of chart audits for accuracy and completion, unsuccessful performance was found for two consecutive months (September and October 2010). There was no evidence to show the facility recognized the unsuccessful performance, investigated the problem, or developed interventions to improve performance. On the basis of present survey findings, it was determined the QA program had not effectively addressed deficiencies first cited on the recertification survey originally completed on July 1, 2010. Failure of the committee to evaluate action plans and provide adequate oversight contributed to the facility's failure to correct the following deficiencies: F 272, F 280, F281, F309, F323, F 431, F 441, F520. Refer to each federal citation for additional information.	{F 520}	cannot attend the QA/QI meeting, s/he will designate an alternate provider to attend in their place. The appropriate personnel will implement plans of action to correct all quality problems identified in the survey process and by the committee. Implementation will include tracking/monitoring plans of action with identification of the root cause, and solutions to implementing plan of action to include deficiencies cited by the survey team in this survey. Acceptable standard levels will be identified to meet the goals of the plans and will be reported to the committee at each meeting. Furthermore a QA/QI Coordinator has been designated to oversee the completion, implementation and effectiveness of the program. This will be monitored by DON, Administration and will be reported to the Board of Trustees through the QA/QI Program.	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535029	A. Building B. Wing	12/2/2010

Name of Facility	Street Address, City, State, Zip Code
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 11/24/2010	ID Prefix F0244 Reg. # 483.15(c)(6) LSC	Correction Completed 11/24/2010	ID Prefix F0274 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 11/24/2010
ID Prefix F0278 Reg. # 483.20(d) - (l) LSC	Correction Completed 11/24/2010	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 11/24/2010	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 11/24/2010
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/01/2010	ID Prefix F0332 Reg. # 483.25(m)(1) LSC	Correction Completed 11/24/2010	ID Prefix F0406 Reg. # 483.45(a) LSC	Correction Completed 11/24/2010
ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 11/26/2010	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 11/26/2010	ID Prefix F0496 Reg. # 483.75(e)(5)-(7) LSC	Correction Completed 12/02/2010
ID Prefix F0498 Reg. # 483.75(f) LSC	Correction Completed 11/24/2010	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TB	Date: 12/15/10	Signature of Surveyor:		Date: 12-13-10
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:		Date:

Followup to Survey Completed on: 7/1/2010 (State)

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO