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

PRINTED: 07/14/2011
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
	535040	A. BUILDING _____ B. WING _____	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1100 BIRCH STREET DOUGLAS, WY 82633

(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 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 nursing assistant ADL - activities of daily living MAR - medication administration record Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interviews, and medical record review, the facility failed to comprehensively assess 1 of 6 sample residents (#22) reviewed for self-administration of medications. The findings were: According to the June 2011 physician orders, resident #22 could keep hemorrhoid ointment, mentholatum ointment, and Theragesic pain relief cream at the bedside. Review of the assessment for self-administration of medications dated 8/22/09 revealed the facility had determined the resident should not self-administer medications. Interview with a family member on 6/28/11 at	F 176	F176 A self-administer drug assessment for all medications for patient #22 will be done to ensure that the resident is deemed to have medications at the bedside as well as a doctors order for them to be at the bed side if the assessment approves that the residents is appropriate for such medications. A monthly audit and room check will be done and presented to QA, to ensure that there are no continued issues with resident #22. Self-administer drug assessments will be done on all residents off of the Alzheimer unit. A monthly audit and room check will be done and presented to QA, to ensure that there are no continued issues w/any residents. The findings will be presented to QA until the issue has resolved itself or for six months. A self administration assessment will be done by DON or designee upon admission. A form will also be added to the admission packet educating family on the fact that all OTC's or prescribed medications need to have a self-administration assessment done w/the resident and a doctor's order before the medication can be kept at the bedside. approved by the IDT 8/25/11	

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

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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AUG 09
WyomingDeptofHealth

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RYU711 Facility ID: WY0019 If continuation sheet Page 1 of 37

This POC accepted call corrections per phone conversation w/ Kelli Lopez, Adult Facility Nurse Surveyor on 8/29/11 @ 0950

AUG 09
Office of Healthcare Licensing and Surveys

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F 176	Continued From page 1 11:50 AM revealed the resident had severely impaired vision. Observation on 6/29/11 at 8:28 AM showed the resident had a tube of oral analgesic and a bottle of 100 tablets of Vitamin C on the bedside table. At that time, LPN #1 stated the medications had been at the resident's bedside for approximately two weeks. At 8:35 AM that day the resident stated s/he was unable to read the labels on the medications. On 6/29/11 at 9:46 AM the DON verified the facility did not have an assessment approving self-administration of medications. She also stated the facility did not have a physician's order for medications at the resident's bedside.	F 176		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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 by: Based on observation, staff interview and medical record review, the facility failed to promote dignity for 1 of 11 sample residents (#35) regarding this resident's uncovered urinary collection bag exposed to public view. In addition the facility failed to promote the dignity for 1 non-sample resident (#44) who waited for a prolonged period of time for assistance to the bathroom. The findings were: 1. According to the medical record, resident #35, required assistance with activities of daily living due to physical impairments resulting from a	F 241		

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F 241	Continued From page 2 stroke. Periodic observations on 6/27, 6/28, and 6/29/11 revealed the resident's partially filled urinary collection bag and drainage tube were uncovered and exposed to public view. Periodic observation also showed, at times, the bag was detached from the wheelchair, and the resident rolled over it and/or stepped on it as it dragged on the floor. During an interview on 6/30/11 at 11:30 AM, the administrator stated the urinary collection bag should be covered. She also stated staff were aware of the problem, but had not identified how they were going to address it. 2. According to the medical record, resident #44, required assistance with toileting due to physical and cognitive impairment. Observation on 6/28/11 from 12:20 PM to 1:05 PM revealed the resident repeatedly requested assistance to the bathroom as s/he wheeled his/her wheelchair in the hallway, moving back and forth from the surveyor to CNA #1. The CNA's response to the resident's repeated request was that it takes two people to transfer the resident, and the resident would have to wait until another staff person was available. At 1:05 PM, forty-five minutes after the resident initially requested assistance, the CNA and the unit coordinator (who is also a CNA) were observed assisting the resident to the bathroom. At that time, they noted the resident had not been incontinent. After urinating the resident gave a sigh of relief at being able to empty his/her bladder.	F 241	F241 A urinary dignity bag will be made to ensure that resident #35 urinary collection bag is not exposed to public view. The dignity bags will be placed for all residents with urinary collection bags. A weekly audit will be done for all residents by the DON or designee, and reviewed at QA until we have resolved the issue. . Resident #44 will not have to wait for any length of time to use the restroom, nor will any other resident have to wait to use the restroom facility wide. We will have put in place that all staff is in-serviced in asking for help when one of the two aids is with another resident. All CNA's and nurses will have two-way radios w/them at all times so there is a means of communication facility wide; a radio will also be kept at the front desk. 8/15/11 DON will monitor on a monthly basis & report to QA.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246		

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F 246	Continued From page 3 preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interviews, and medical record review, the facility failed to accommodate the visual needs of 1 of 2 sample residents (#22) with severe visual impairment. In addition, the facility failed to provide 1 of 2 sample residents (#13) who utilized hearing devices with treatment and services to promote use of the device and improve hearing. The findings were: 1. Review of the medical record showed resident #22 had a diagnosis of glaucoma, and interview with a family member on 6/28/11 at 11:50 AM revealed the resident had a severe visual impairment that, according to two optometrists, could not be improved. The family member reported the resident, as well as the family, had asked staff to identify the resident's food and its placement on the plate. Previous observation of meals on 6/27/11 at 5:54 PM and, on 6/28/11 at 7:35 AM, showed staff failed to identify the food items and location on the resident's plate. During an interview on 6/29/11 at 10:20 AM, the resident stated s/he had asked staff to identify the placement and items served; she further stated that was not done. Review of the care plan showed the facility failed to address appropriate dining interventions to accommodate the resident's visual impairment.	F 246	F246 Resident #22 will have a care plan identified for her so that staff understands that they are to identify her food on her plate. Resident #22 does not like have her food identified by a clock placement. The care plan will be updated on a quarterly basis, and periodic audits will be done on a monthly basis to ensure that the staff is telling resident #22 what is on her plate. The audits will be brought to QA until the issue is resolved and revisited quarterly thereafter. The care plan IDT will meet to discuss any other residents in the facility that has visual issues that need identified as needing assistance with the placement of their food. Staff will be in-serviced on who the residents are that the IDT has identified as needing assistance as well as how to identify residents whose condition has changed and may now need assistance. Resident #13 will be able to wear his hearing aids and be able to hear the TV. Resident #13 will have his ears checked weekly in according to the MAR, and if his ears need to be cleaned, the Debrox is on the MAR as standing order. The hearing aids will be taken to an audiologist to ensure they work properly. Staff will be educated on how to insert the hearing aids properly. The cleaning of his ears and checks as well as placement of his hearing aids will be added to his care plan.	

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F 246	Continued From page 4 2. Observation on 6/27/11 at 2:45 PM and 6/28/11 at 7:35 AM showed the television was on for resident #13, but the sound was low. The observation also revealed the resident was not wearing hearing aids. On 6/28/11 at 7:50 and 9:46 AM, two different family members said the resident was very hard of hearing. Both family members also stated the resident had hearing aids but could not use them due to wax in his/her ears. During the interview at 9:45 AM, the family member stated the resident's hearing aids were repaired some time ago, but s/he did not know if they still worked. S/he further stated the resident was no longer able to insert them independently. Review of the care plan showed no instructions for staff to clean the resident's ears or to insert the hearing aids. On 6/28/11 at 6:30 PM the DON confirmed the resident no longer wore the hearing aides due to the build up of wax in his/her ears. The DON also acknowledged that nursing could clean the resident's ears and insert the hearing aids.	F 246	This will be discussed on a weekly basis until the issue is resolved, it will also be brought to QA on a monthly basis until resolved and then quarterly after words. A set of head phones will be purchased so that resident #13 can listen to the TV without difficulties. The care plan IDT will meet to ensure that we identify other residents who are hard of hearing and that we are giving them the proper adaptations. This will be reviewed monthly and brought to QA monthly until resolved and then quarterly after that.	8/15/11
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to develop and implement meaningful and individualized activities for 2 of 11 sample	F 248		

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F 248	Continued From page 5 residents (#13 and #35). The findings were: a. Observation on 6/27/11 at 2:45 PM and 6/28/11 at 7:35 AM showed resident #13 was watching television, but the sound was low. Interviews with family members on 6/28/11 at 7:50 and 9:45 AM revealed the resident was very hard of hearing. However, both family members stated the resident had hearing aids but could not use them due to wax in his/her ears. According to the activity assessment and 3/16/11 care plan, the resident's main activity was watching television. When asked on 6/28/11 at 1:30 PM if s/he could understand conversations on television, the resident replied, "No." Interview with the activity director on 6/30/11 at 8:07 AM revealed the resident refused most activities, but it was unknown if this was due to lack of interest or inability to hear. The activity director confirmed the resident's primary activity was watching television, but acknowledged the inability to hear and understand conversations most likely diminished its meaningfulness for the resident. The director further stated that a one-to-one activity program for the resident was lacking. b. During an interview on 6/29/11 at 4:40 PM resident #35 talked for an hour about how much s/he enjoyed his/her career as a veteran and after having spent years being actively involved in something s/he enjoyed, it was boring to sit all day at the facility and, "do nothing". Review of the 10/16/10 activities evaluation showed the resident's past career interests had not been included in the current activity pursuit patterns and preferences. According to the comprehensive care plan, the approaches that addressed the resident's need for meaningful and	F 248	F248 Resident #13 will have more one on one activities. Activities will develop a one on one to get resident #13 outside of his room, if he refuses the one on one outside of his room then the one on one will be added to watch TV with resident. All residents will be evaluated for one on one's after that the IDT care plan team will be review on a quarterly basis all residents for a one on one activity. The one on one documentation will be brought to QA on a monthly basis until the issue is resolved and then quarterly thereafter. Resident #35 will have his room more decorated on his career. Resident #35 will have activities centered on his career. A bin will be set up for each resident in the Alzheimer's unit will have individualized activities set up specifically for them. This will be audited on a quarterly basis at the care plan meetings and brought to QA monthly until resolved and then quarterly thereafter. Staff will be in-serviced on the one on one's however activities will be responsible for providing the one on one's with the residents.	8/15/11

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F 248	Continued From page 6 Individualized activities included the following: Individual activities, reading, television, music, visiting with family and other residents, card games, bingo and community outings. During an interview on 6/29/11 at 6:30 PM the unit coordinator stated staff were aware of the resident's veteran status and career interests, but they had not thought about developing an activity related to this interest. Observations on 6/27/11 from 2:20 PM until 6:00 PM revealed the resident did not participate in the afternoon outside activity at 2:20 PM. At 6:00 PM the scheduled activity was the television news and the resident ate supper during the broadcast. On 6/28/11 the resident refused to participate in the morning "juice and jive" activity. Later that day s/he participated in the card playing activity for approximately fifteen minutes, and listened intermittently to the music that was played for the afternoon activity.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272		

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F 272	Continued From page 7 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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive assessment for each triggered area for 1 of 11 sample residents (#22). The findings were: Review of the 9/3/10 annual MDS assessment showed resident #22 required comprehensive assessments for delirium, behaviors, activities of daily living, falls, and psychotropic medications. Review of the information designated as the comprehensive assessment for each area showed the causes and contributing factors were	F 272	F272 A compressive assessment for resident #22 will be done on delirium, behaviors, ADL's, falls and psychotropic medications. Comprehensive assessments will be done on admission, with significant change and annually this will be done for resident #22 as well as all of the residents. The CAA's will be completed within specified RAI timeframe and evaluated by IDT during care conference that will reflect resident specific data with analyzing and orating care plans specific to the comprehensive evaluation for resident #22 as well as all of the residents. Staff will be educated on the importance of the assessments being done on a timely basis. An audit of all residents' compressive evaluations will be done to ensure that they are all up to date, and then reviewed quarterly. The evaluations will be brought to QA on a monthly, until the issue is resolved and then quarterly thereafter.	8/15/11

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F 272	Continued From page 8 not identified. Nor was the impact on the resident's ability to function identified and evaluated. In addition, the facility failed to analyze the data documented in the pain assessments. Interview with the MDS coordinator on 6/29/11 at 4:38 PM confirmed the assessments were not comprehensive.	F 272	F273 Admission compressive assessments are to be done 14 days after admission on all admissions, excluding readmissions in which there is no significant change in the residents physical or mental condition. 1) On admit MDS nurse will add resident to spreadsheet outlining deadlines according to the RAI manual. The spread sheet will include the admission date and the date the Comprehensive, CAA's and Care plans are due to ensure the deadlines are met and/or not missed. This will be audited quarterly during resident specific care conferences. 2) MDS nurse or designee to do all submissions and coding according to the RAI manual guidelines. MDS nurse will audit annual/admit MDS during quarterly care planning to ensure that the MDS's are coded correctly for the year. All new admissions for the month will be brought to QA to ensure that the MDS's are done within 14 calendar days after admission. They will be brought to QA every month until the issue is resolved and then quarterly thereafter. MDS coord. will receive education on the requirements &c	8/15/11
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure admission comprehensive assessments were completed within 14 days for 2 of 4 sample residents (#13, #27). Furthermore, the assessment for resident #27 was miscoded. The findings were: 1. According to the face sheet, resident #13 was admitted to the facility on 9/23/10. Review of the admission MDS assessment showed it was not completed until 10/20/10, twenty-seven days after admission. On 6/29/11 at 4:40 PM the MDS coordinator confirmed the assessment was late. 2. Medical record review showed resident #27 was admitted on 6/4/10, and the 14 day Medicare	F 273		

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F 273	Continued From page 9 assessment was completed on 6/28/10. However, detailed review of the medical record failed to produce an admission MDS assessment. On 6/30/11 at 9:35 AM the MDS coordinator reviewed the dates and confirmed the assessment was late. She also stated the Medicare assessment was the admission MDS assessment, but it was not coded as such.	F 273	F274	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed to complete significant change assessments for 1 of 3 sample residents (#13) who required that type of assessment. The findings were: According to the 10/20/10 MDS assessment, resident #13 weighed 182 pounds. Comparison of that assessment with the quarterly assessment	F 274	A comprehensive assessment for resident #13 will be done. Compressive assessments for all residents who have been deemed to have a significant change will be done 14 days after we determine there should be a significant change according to regulations. The MDS nurse will create a form outlining SCIS guidelines and in-service direct care staff on how to identify significant changes, these items will be discussed at nurses briefing and evaluated weekly after weight and skin. At this time IDT will determine if issues merit a significant change. MDS nurse will also make a form and bring to QA to map MDS information quarterly to identify any changes missed.	8/15/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1100 BIRCH STREET DOUGLAS, WY 82633

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F 274	Continued From page 10 dated 1/11/11 showed the resident weighed 160 pounds, a loss of 22 pounds or 12.08 percent. Further comparison of the 1/11/11 quarterly with the quarterly dated 4/6/11 showed the resident had experienced the following changes in functional ability: a. Improved bed mobility from requiring extensive to limited assistance (3 to 2); b. Improved toilet use from requiring total to extensive assistance (4 to 2); c. Improved bathing from requiring total to extensive assistance (4 to 3); however, d. ambulation in the corridors declined from occurred once or twice to not occurring at all over a seven day period (7 to 8). Observation on 6/28/11 at 1:36 PM showed the resident was very weak and shaking after ambulating to the bathroom. At that time the resident denied pain but stated s/he was "just that weak" and could not ambulate in the halls. Interview with the MDS coordinator while reviewing the criteria for significant change assessments on 6/29/11 at 10:10 AM confirmed that two significant change assessments were missed.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		

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F 279	Continued From page 11 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop and implement a care plan that included all identified problems for 1 of 12 sample residents (#27). The findings were: Observation on 6/28/11 at 3:40 PM revealed resident #27 had a solid bright red rash on the inner thighs, perineum, and buttocks. The skin was dry and peeling in spots. Splotchy areas on the resident's back were also red, and the resident complained of itching while scratching his/her back and sides. Review of the care plan showed care and treatment for the rash was not addressed. Review of the nursing notes showed the rash was first identified in March 2011. Interview with the administrator, DON, and social service director on 6/29/11 at 2 PM confirmed the date the rash was identified and that it was not addressed in the care plan.	F 279	F279 The rash on resident #27 will have a care plan done addressing the rash. Resident #27 will have been seen times 4 by the dermatologist. Celiac Sproo and stool cultures and O&P pending. Facility and doctors will work closely to ensure that the rash is dissolved. 1) Wound care team will create care plan when problems are noted and observed by team. 2) During nurses briefing any ongoing resident issue not already addressed in care plans ~~can~~ will be addressed at that time for review, and care planned at that time with the IDT daily. 3) Care plans reviewed quarterly at care conference one hour prior to the start of care conference. 4) The MDS nurse will update care plans weekly with care conference, and will be brought to QA on a monthly basis. Care plans will be reviewed on a monthly basis at QA until the issue is resolved and then quarterly thereafter.	8/15/11
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 12 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, family, and staff interviews, the care plan was not updated with revised goals and interventions to reflect the current status of 2 of 12 sample residents (#13, #22). The findings were: Review of the care plan for resident #13 showed the goals and interventions related to communication were developed on 10/1/09; a second care plan for communication was dated 1/15/10. The care plan for urinary incontinence was dated 9/17/09, the one for activities was initially dated 9/21/09, and interventions to	F 280	F280 Care plans for resident # 13 have been updated for falls, urinary incontinence, and communication. ~~The care plan will include a bowel and bladder, hearing aids and wax build up of the ears.~~ A post fall assessment will be done. The activity care plan will address residents hearing loss and preference of remaining in room. Resident #22 will have care plans updated including visual needs of resident while dining. During nurses briefing any identified problems for all residents will be addressed at this time and will be addressed and implemented on the care plans to dissolve identified problems. 1) Care plans reviewed quarterly at care conference one hour prior to the start of care conference 2) MDS nurse updating care plans weekly with care conference, and will be brought to QA on a monthly basis until the issue is resolved and then quarterly thereafter.	8/15/11

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F 280	Continued From page 13 prevent falls were developed on 9/15/10. The following concerns were noted. a.) Interview with CNA #3 on 6/28/11 at 9:10 AM revealed a toileting routine was not in place for the resident. Refer to F315 for additional information regarding this resident's urinary incontinence. b.) The care plan for communication instructed staff to look the resident in the eyes and try for more than a one word answer. No instructions were included regarding the resident's hearing aid. c.)Despite the resident's recent documented falls, new interventions based on the post-fall assessments were lacking. d.) The activity care plan lacked current interventions based on the resident's weakness, hearing loss, and preference for remaining in his/her room. Each of these care plans was dated as reviewed quarterly, but evidence they were revised was lacking. On 6/29/11 at 3:24 PM the DON confirmed the current care plan lacked appropriate interventions. 2. Refer to 246 for failure to develop an appropriate care plan to meet the visual needs of resident #22 while dining.	F 280		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F 285		

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F 285	Continued From page 14 (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission— (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 285	F285 PASARR I will be done on all admissions before admit date. A PASARR II will be done if the PASARR I triggers for an II to be done. Social Service will attend an in-service from Lisa Crisp with Wyoming Medicaid. PASARR's for resident #'s 31, 48 & 44 will be done if not already done so. An in-service will be done for our local doctors on the importance of the PASARR's. The PASARR will be questioned at all admission meetings with the admission IDT. Staff and doctors will be educated on the regulations for the PASRR requirements for MI and MR. All new admissions for the month will be audited at QA monthly until the issue is resolved and then quarterly thereafter.	8/15/11

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F 285	Continued From page 16 interview, the facility failed to ensure the pre-admission screening assessments were completed prior to admission for 2 of 12 sample residents (#31, #48) and 1 non-sample resident (#44). The findings were: 1. According to the medical record for resident #31, the resident was admitted to the facility on 10/15/10. Further review showed the pre-admission screening assessment I (PASRR I) was completed on 10/18/10. As a result of the PASRR I, an additional pre-admission screening assessment (PASRR II) was required and should have been completed prior to admission. 2. Review of the medical record for resident #44 showed s/he was admitted to the facility on 6/15/11, but issues regarding the need for a PASRR II had not been resolved before or after the resident was admitted. 3. Review of closed medical record for resident #48 revealed the resident was admitted to the facility on 6/21/11. Further review of the record revealed facility staff did not complete the PASRR I until 6/23/11. 4. Interview on 6/28/10 at 3:05 PM with the social services director confirmed the PASRRs had not been completed as required for residents #31, #48, and #44.	F 285		
F 309 SS=D	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	F 309		

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F 309	Continued From page 16 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure hospice services were coordinated for 2 of 2 residents (#1, #28) who were reviewed for hospice services. The findings were: Review of the physician orders for residents #1 and #28 showed orders for the evaluation of hospice services. The order for resident #1 was dated 5/6/11. Review of the June 2011 physician recapitulation of orders showed resident #28 had received comfort care/hospice services since 10/26/10. Review of the medical records for both residents showed a hospice plan of care was lacking, and the facility's care plans failed to address any services provided by the hospice facility. Interview with the DON on 6/29/11 at 1:45 PM revealed she called the hospice facility and they faxed the plans of care for these two residents; both plans were dated 6/17/11. The DON then verified the medical records did not contained a coordinated plan of care between the two facilities.	F 309	F309 For resident #'s 1 and #28 will have coordinated care plans between hospice and the facility twice a month. The facility will either call in on conference call or be there in person with the hospice's IDT. Hospice will also attend the facilities quarterly care plan meetings. There will be a three ring binder containing the plans of care for all hospice residents and it will be kept at the nurses' station. The two care plans will work together to ensure the best for the residents. This will be done for all residents on hospice. The hospice residents care plans will be monitored on a monthly basis at QA until resolved and then quarterly thereafter. After the death of a resident on hospice, the care plan will become part of the closed medical record 8/15/11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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	F 315		

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F 315	Continued From page 17 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, staff interview, and medical record review, the facility failed to ensure 1 of 4 (#13) residents with urinary incontinece received appropriate treatment and services to maintain normal bladder function and prevent urinary incontinence. The findings were: According to the 4/6/11 quarterly MDS assessment, resident #13 was always incontinent of urine. Review of the care plan showed the resident needed assistance with toileting, but staff were only to toilet him/her at night. Continuous observation on 6/27/11 from 2:45 until 5:54 PM (three hours, nine minutes) showed the resident was not toileted nor prompted to use the toilet independently. On 6/28/11 at 9:10 AM CNA #3, who was providing care for the resident, stated there was no routine toileting program for the resident. She further stated the resident was toileted before breakfast and would not be toileted again until before lunch. Continuous observation from 10:30 AM until 12:15 PM showed the resident was not toileted. At 1:35 PM that day the CNA stated the resident had not been toileted as she was busy and "forgot." At 1:36 PM, she and CNA #4 assisted the resident to the bathroom. By that time the resident was incontinent of urine.	F 315	F315 Resident #13 will have compressive assessments done to see if resident is a good candidate to be placed on a bowel and bladder program. The assessment will reflect on the care plan. The compressive assessments on bowel and bladder will be done on all residents. Again the care plans will be reviewed monthly and brought to QA monthly until resolved and then quarterly thereafter. In-service CNA's that all residents need to be toileted every 2 hours regardless of B&B issues and care plans.	8/15/11
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 18 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the consistent provision of range of motion exercises and/or application of restorative devices for 2 of 2 sample residents who required restorative services (#1, #9). The findings were: 1. Review of the 5/27/11 significant change MDS assessment for resident #1 showed s/he had limited range of motion for both the upper and lower extremities that affected both sides of the resident's body. Review of the resident's hospice care plan (not part of the medical record until faxed to the facility on 6/28/11) revealed some of the resident's pain might be caused by "immobility", and it was noted that the resident had contractures. Under this problem area in the hospice care plan, it further showed "needs coordinated." The following concerns were identified: a. Review of the facility's care plan for this resident showed a care plan for the problem of Parkinson's Disease, muscle rigidity and slow movements. The goal was to keep the muscles functional and useful. One of the interventions to	F 318	F318 Resident #1 will be placed on restorative nursing. Resident # 9 will be placed on restorative nursing. DON will call Buffalo facility to see how there restorative program is operated. Will address all prospective residents in need of restorative services on a weekly basis at weekly Medicare meeting; all residents will be evaluated to determine if restorative is needed, including residents with hospice care. Staff will be educated on the importance of restorative nursing. Restorative residents will be monitored on a weekly basis and brought to QA monthly until resolved and then quarterly thereafter. In the absence of the restorative aide, the MDS coord will step in to assist c restorative. bv	8/15/11

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F 318	Continued From page 19 achieve this goal was to have the resident participate in the restorative program and exercises. However, this care plan had been discontinued; there was a slash mark through the entire page. There was a note documented on the page that showed the date 6/15/11 and "NA (not applicable) related to Hospice start 6/9/11." Further review of the care plan showed a new goal and interventions were not developed related to this problem area. b. Review of the June 2011 restorative service log revealed this resident was not on a program, and restorative nursing service were not being provided. 2. Review of the 6/2/11 restorative referral for resident #9 showed the resident had right hand contractures; the restorative goal was to increase the range of motion in the right hand through massage and a splint schedule. The duration of the restorative program was for four weeks with the services being provided three to four times each week. Review of the restorative records showed the last time the resident received restorative services was on 6/3/11. Periodic observations on 6/27- 6/29/11 revealed the resident's right hand was contracted; s/he did not receive restorative services, nor did s/he have a splint or supportive device for the right hand. Interview with CNAs #2 and #4 on 6/29/11 at 4:45 PM revealed the residents who were scheduled to receive restorative services, including resident #9, had not received it for several weeks. The CNAs also stated they had not been instructed to provide restorative services when the restorative aide was absent. Interview with the unit coordinator on 6/29/11 at 5:30 PM confirmed the lack of restorative services. She stated the	F 318		

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F 318	Continued From page 20 resident had a right hand splint in May 2011 that made his/her hand sore. She also stated the area was currently healed, but staff had not talked with the therapist about a replacement supportive device. 3. Interview with the DON on 6/29/11 at 3:20 PM revealed the restorative nursing program was short staffed due to employee illness. She stated the program was not functioning well.	F 318		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment for residents in one of three resident bathing rooms. The findings were: Observation on 6/27/11 at 4 PM, and on 6/29/11 at 11:48 AM, revealed the door to the residents' bathing suite across from the nurses station was unlocked. In addition, two horizontal stacked cabinets inside the bathing room were also unlocked. Sitting on top of the cabinet were two pad locks. Inside the bottom cabinet was a gallon container of germicidal bleach with the active ingredient being sodium hypochlorite. According	F 323	F323 All staff will be in serviced on the importance of locking the cabinets in the bathing suites. The bath aids on the observed days will be counseled. Maintenance or designee will monitor on a daily basis. If there is a problem the DON or designee will be notified immediately. The results will be monitored on a monthly basis at QA until resolved and then quarterly thereafter.	8/15/11

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DOUGLAS CARE CENTER LLC	1106 BIRCH STREET DOUGLAS, WY 82633

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F 323	Continued From page 21 to the Columbia Encyclopedia 6th edition, 2006, sodium hypochlorite is harmful if swallowed and causes skin and eye irritation. In addition, also inside the cabinet was an opened box containing five safety razors. Interview with maintenance manager and facility administrator on 6/29/11 at 11:48 AM confirmed the cabinet should be locked.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain an error rate under 5 percent (%). Out of 41 opportunities for error, 5 errors were committed which resulted in an error rate of 12.19%. The residents affected by these errors were sample resident #22 and non-sample residents #10, #32, and #40. The findings were: 1. Observation during the medication pass on 6/27/11 at 5:46 PM revealed RN #1 failed to administer the scheduled dose of 1000 micrograms cyanocobalamin (vitamin B12) injection to resident #10. After checking the medication cart, the RN stated she was unable to administer the medication because it was not available. Review of the medical record, physician's orders and June 2011 MAR revealed the physician ordered vitamin B12 injections to be administered monthly on 2/14/09. This review	F 332	F 332 Resident #10 vitamin B12 was dc'd in April 2011 and reordered in July 2011. The resolution is that all residents receiving weekly, monthly etc. injections will be done on the 20th of each month and readily available. A reminder will be set up on DON's email to remind nursing staff of injections on the 18th of every month to ensure that the medication is there. Resident # 22 the MAR's were reconciled to the prescription and the Lisinoprol was made available. The MDS nurse will compare MAR's to physician orders monthly. Nurses will be in-serviced to verify all medications being administered at all med passes. Resident #32 Novalog sliding scale was corrected. It was a transcription error. The medication has been clarified and verified and put on physician orders and MAR. The MDS nurse will compare MAR's to physician orders monthly. Nurses will be in-serviced to verify all medications being administered at all med passes.	

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F 332	Continued From page 22 also revealed the injections had not been given in April, May or June 2011. Interview with the DON on 6/29/11 at 10:20 AM revealed the medication was discontinued in March 2011, but staff had not put the signed physician's order in the medical record. Interview on 6/30/11 at 1:45 PM with the physician revealed the medication was ordered because the resident had pernicious anemia and the physician did not know the medication had been discontinued. The interview also revealed he did know the resident had not received the medication for the past three months. 2. While preparing medications for resident #22 on 6/29/11 at 8:20 AM, LPN #1 was observed to circle Lisinopril on the MAR. She stated it was not available and the circle meant it was not administered. Further observation showed the LPN administered medications, including Timolol eye drops 0.5%, at 8:30 AM. Reconciliation of the medication pass showed Lisinopril was ordered daily to control high blood pressure and Timolol eye drops 0.25% were ordered for glaucoma. Review of the MAR showed the instructions were for 0.25 % of Timolol to be administered. At 8:50 AM that morning the LPN verified Timolol had been administered incorrectly the last few times it was instilled in the resident's eyes. Two medication errors occurred with this medication pass. 3. Observation on 6/27/11 showed LPN #2 prepared and, at 4:32 PM, administered nine units of Novolog insulin for resident #32 whose blood sugar reading was 228. Reconciliation of the medication pass showed the amount of insulin ordered for a blood sugar of 228 could be either six or nine units. Further review of the order	F 332	All nursing staff has been counseled on the importance of verifying the prescription against the MAR. DON or designee will do monthly med pass audits. Resident #40 Preser Vision vitamins have been made available. Sunday night nurses will monitor on a weekly basis that all medications are inventoried and any medications that will run out that week will be faxed to pharmacy on Sunday nights. DON or designee will monitor all of the above and bring to QA on a monthly basis until resolved and then quarterly thereafter.	8/15/11

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F 332	Continued From page 23 sheets and the MARs showed the order had been entered that way for the past six months. On 6/28/11 at 10:20 AM the DON confirmed the order should have been clarified. 4. On 6/28/11 at 5:20 PM LPN #2 was observed while preparing medications for resident #40. The LPN was unable to find Preser Vision vitamins and circled the medication on the MAR. At 6:24 PM that evening the LPN stated the medication was reordered, but she was unable to find the faxed request to the pharmacy. Reconciliation of the medication pass with the orders showed the vitamins were ordered twice daily.	F 332		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the menu spreadsheet, the facility failed to ensure the planned amount of food was served for 5 of 6 residents (#7, #9, #10, #30, #31) whose meals were observed during service. The findings were: According to the 6/28/11 noon menu, the following quantities of food were planned to be served: a. Three ounces of mechanically altered soft	F 363	F363 1) Staff will be in serviced on how to read and prepare the therapeutic cards to ensure that all residents receive the correct portions of food. DM is auditing meal servings for 1 to 2 meal servings on a weekly basis, and will bring results to QA on a monthly basis until the issue is resolved, and then quarterly thereafter.	8/15/11

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F 363	Continued From page 24 crab cakes; this would be equivalent to a #10 size scoop. b. Two #8 size scoops of the pureed crab cakes, this is equivalent to 1 cup. c. The cole slaw was planned for a 1/2 cup serving equal to a #8 size scoop. Observation of the noon meal on 6/28/11 at 11:50 AM showed the cook served the following items in the following quantities which did not correspond to the planned menu: a. Mechanically altered soft crab cakes were served to residents #9 and #10 using a number sixteen scoop, equivalent to 1/4 cup or 2 ounces. b. A pureed mixture of crab cakes and bread were served to residents #30 and #7 using a number sixteen scoop, equivalent to 1/4 cup. c. Cole slaw was served to resident #31 using a number twelve scoop, equivalent to 1/3 cup. Interview with the dietary manager on 6/28/11 at 2:20 PM revealed the serving sizes on the menu needed to be followed.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F371 1) All staff will be in serviced in accordance of the Food Code 2009, U.S. Public Health Service, and 2-301.14. The in-service will be conducted by the RD, on a quarterly basis or as any new hires are hired on staff. The ICP will in-service all staff a quarterly basis. 2) The stand mixer was cleaned. The stand mixer will be cleaned after every use. Staff has been in serviced on the cleaning schedule of the stand mixer and will have to sign off on the cleaning schedule on a daily basis.	

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F 371	Continued From page 25 by: Based on observation and staff interview, the facility failed to ensure proper hand hygiene techniques were used, and that equipment and ceiling vents were clean. The findings were: Handwashing Observations on 6/28/11 from 11:02 AM to 11:10 AM revealed dietary aide #1 was pouring resident beverages. The dietary aide wore disposable gloves during this task. On six separate occasions during this time frame, the aide handled the walk-in refrigerator door with her gloved hands. At no time during the task were the gloves changed or the dietary aide's hands cleansed. Interview with the dietary manager on 6/28/11 at 2:20 PM verified the aide should have washed her hands and changed gloves each time the walk-in door was handled. According to Food Code 2009, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands. In addition, two dietary staff (the dietary manager and dietary aide #1) were observed to use poor technique when washing their hands. On 6/28/11 at 11:10 AM and 11:39 AM the staff members used their clean hands to turn off the water faucets prior to taking a paper towel. According to Food Code 2009, U.S. Public Health Service, 2-301.12 "(C) TO avoid recontaminating their hands or surrogate prosthetic devices, FOOD EMPLOYEES may use disposable paper towels or similar clean barriers when touching surfaces	F 371	The cleaning schedule is given to the DM on daily basis. The DM will do periodic audits of the stand mixer. 3) The blade on the can opener has been cleaned. The can opener is to be cleaned after every use and placed in the dish washer every evening. Staff has been in serviced on the cleaning schedule of the can opener and will have to sign off on the cleaning schedule on a daily basis. The cleaning schedule is given to the DM on daily basis. The DM will do periodic audits of the can opener. 4) The ceiling vents have been cleaned. The vents have been put on a weekly cleaning schedule. Staff has been in serviced on the cleaning schedule of the ceiling vents and will have to sign off on the cleaning schedule on a weekly basis. The cleaning schedule is given to the DM on daily basis. The DM will do periodic audits of the ceiling vents. The audits and signed off cleaning schedule will be brought to QA to ensure the problem doesn't occur again and will do so monthly until resolved and then quarterly thereafter. The rest of the kitchen will be kept cleaned.	8/15/11

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F 371	Continued From page 26 such as manually operated faucet handles on a HANDWASHING SINK or the handle of a restroom door. Equipment: Observation on 6/27/11 at 12:56 PM and 6/28/11 at 11 AM revealed the stand mixer was not in use, and had not been adequately cleaned. There were dried splatters of batter/food on the underside of the mixing arm. In addition, the can opener mounted on the counter was not clean. The blade of the can opener had a build-up of food debris. Finally, two ceiling vents were visibly soiled with grease and dust build-up. One vent was located over a food preparation table, the other over a food and clean dish storage area. Interview with the dietary manager on 6/28/11 at 2:20 PM revealed, that although there was a cleaning schedule, these items needed better or more frequent cleaning. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	F 387		

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F 387	Continued From page 27 A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 1 of 3 sample residents (#13) admitted within the past year received physician visits as required. The findings were: Review of the admission face sheet showed resident #13 was admitted on 9/23/10. Detailed review of the medical record showed no evidence of physician visits every thirty days for the first ninety days following the admission. On 6/30/11 at 9:10 AM, the DON, MDS coordinator, and social services director confirmed the visits did not occur; they all thought the requirement was only for Medicare residents.	F 387	F387 The copy of the physician visit policy has been emailed to all admitting physician. A new medical records staff has been hired and will be putting a program together to monitor physician visits. Administrator or designee will notify physicians on a monthly basis of residents that need to be seen at the beginning of each month via email. This will be done for resident #13 and all other residents. An audit of physician visits will be brought to QA on a monthly basis, until resolved and then quarterly thereafter. 8/15/11	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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 administering of all drugs and biologicals) to meet the needs of each resident.	F 425		

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F 425	Continued From page 28 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, medical record review, and staff interview, the facility failed to ensure medications were available for administration as ordered. Of the 10 residents observed during medication passes, this failure affected 1 sample (#22) and 2 non-sample (#10, #40) residents. The findings were: On 6/28/11 at 7:30 AM RN #2 stated medications were sent from the regular pharmacy after they were reordered. She further stated the facility had a back-up pharmacy but staff could not contact them directly and someone had to pick up the orders. At 6:24 PM that evening LPN #2 stated the facility was to fax the label to the regular pharmacy in time for refills to be sent before they were needed. Failure of this system was identified as follows: a. While preparing medications for resident #22 on 6/29/11 at 8:20 AM, LPN #1 was observed to circle Lisinopril and Restasis on the MAR. She stated the medications were not available and the circle meant neither medication was administered. According to the physician's orders, Lisinopril was ordered daily and Restasis twice daily. b. On 6/28/11 at 6:20 PM LPN #2 was unable	F 425	F425 Residents #22, 10 and 40 and all residents will have all medications readily available. Sunday night nurses will monitor on a weekly basis that all medications are inventoried and any medications that will run out that week will be faxed to pharmacy on Sunday nights. DON or designee meets with pharmacy consultant meet on a monthly basis to address any concerns. DON or designee will monitor weekly and bring to QA on a monthly basis until resolved and then quarterly thereafter.	8/15/11

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F 425	Continued From page 29 to find Preser Vision vitamins for resident #40. The LPN circled the medication on the MAR. Review of the orders showed the resident was to received the vitamins twice daily. c. Refer to F332 for information regarding the facility's failure to ensure monthly vitamin B12 medication was available for resident #10. On 6/30/11 at 1:05 PM the DON confirmed the present system did not ensure medication delivery in a timely manner. She stated she had had to make several after-hours visits to the back-up pharmacy to pick up medications. She further stated the regular pharmacy was not being notified soon enough to refill and deliver medications in time for administration as ordered.	F 425		
F 441 SS=E	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, 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	F 441	F441 All ancillary staff and DCC staff and non DCC staff will be in serviced on infection control practices, particularly hand washing and gloving. DON or designee will do periodic observations and interventions if necessary on a bi-weekly basis of all disciplines. The results will be brought to QA on a monthly basis until resolved and then quarterly thereafter.	8/15/11

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F 441	Continued From page 30 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, medical record review, and staff interview, the facility failed to ensure staff consistently followed appropriate infection control practices during wound care and the provision of personal care during random observations for 2 sample resident (#9, #21). In addition, the facility failed to include the ancillary staff in their infection control training and education program. The findings were: 1. On 6/28/11 at 3:05 PM physical therapy assistant (PTA) #1 was observed while changing a dressing for resident #21. After removing the old dressing and wound packing, the PTA failed to change her gloves prior to repacking the pressure ulcer and applying a new dressing. When interviewed at 3:55 PM that afternoon, the PTA confirmed she had not changed her gloves.	F 441		

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F 441	Continued From page 31 She stated it was not her usual practice to change gloves before applying new packing or dressings. 2. Observation on 6/28/11 at 1:15 PM revealed CNA #1 assisted resident #9 into the bathroom and she removed and discarded the soiled disposal brief. Then she pulled the clean brief up to the resident's thighs. After the resident independently cleansed his/her perineal area, the CNA pulled the clean brief up over the resident's buttocks and touched the resident while assisting in the transfer to the wheelchair. The CNA completed the above tasks without performing hand hygiene or wearing gloves. Interview with the CNA at that time revealed she knew she should have worn gloves and used hand hygiene, but she "forgot". 3. During an interview on 6/30/11 at 12:44 PM, the infection control practitioner (ICP) stated she covered infection control practices at the major inservice held on 5/2/11. The ICP stated handwashing was included for the nursing staff, and their handwashing practices were monitored. However, the education and surveillance did not include other facility departments (such as dietary, housekeeping, and maintenance) or contracted staff such as physical and occupational therapy.	F 441		
F 502 SS=D	483.75(l)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 502	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain laboratory tests as ordered for 1 of 11 sample residents (#22). The findings were: According to the physician's orders, originally dated 9/2/10 and continued through June 2011, resident #22 was to have a complete blood count (CBC) and basic metabolic panel (BMP) done every three months. Review of the laboratory test results showed the last CBC and BMP results were dated 12/3/10. After checking with the laboratory, the DON stated on 6/29/11 at 3:24 PM that the laboratory tests were omitted in March and June 2011.	F 502	F502 Resident #22 had BMP and CBC done on 6/30/11. DON will have reminders put on outlook calendar of quarterly and other scheduled labs to be done on resident #22 and all residents. The reminders will be set up one day prior to lab being due and day of lab due. Staff will be educated on the reminder calendars. The labs done for month will be reviewed at QA on a monthly basis until issue is resolved and then quarterly thereafter. The QA will review 1) that labs were done on timely basis and 2) that results of labs	
F 507 SS=D	483.75(l)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory reports for 1 of 11 sample residents (#22) were filed in the medical record. The findings were: According to the physician's orders, originally dated 9/2/10 and continued through June 2011, resident #22 was to have a digoxin level done every three months. Detailed review of the medical record showed digoxin levels dated	F 507	are noted and filed in charts.	8/15/11

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F 507 SS=D	483.75(l)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory reports for 1 of 11 sample residents (#22) were filed in the medical record. The findings were: According to the physician's orders, originally dated 9/2/10 and continued through June 2011, resident #22 was to have a digoxin level done every three months. Detailed review of the medical record showed digoxin levels dated	F 507	F507 Resident #22's BMP, Dig level and CBC done on 6/30/11 and was placed in chart. DON will have reminders put on outlook calendar of quarterly and other scheduled labs to be done. The reminders will be set up one day prior to lab being due and day of lab due. The labs done for month will be reviewed at QA on a monthly basis until issue is resolved and then quarterly thereafter. The QA will review 1) that labs were done on timely basis and 2) that results of labs are noted and filed in charts. All residents will be added to the outlook calendar for all lab work to be done when due. SO	8/15/11

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F 607	Continued From page 33 12/3/10 and 6/21/11 were filed, but there was no test result for March 2011. On 6/29/11 at 3 PM the DON confirmed that test result had to be obtained from the laboratory.	F 607		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical records were accurately documented, complete and readily accessible for 6 of 12 sample residents (#1, #13, #15, #22, #28, #45) and one non-sample resident (#10). The findings were: 1. According to the progress notes in the medical record, resident #22 was last seen by a physician on 1/6/11. When asked for additional progress notes on 6/29/11 at 5:30 PM, the DON was unable to locate any. The DON contacted the physician's office and had the notes faxed to the facility on 6/29/11. Review of the notes showed	F 514	F514 1) Resident #22 has had all physician visit notes placed in medical record. 2) Resident #13 has had all physician visit notes placed in medical record. 3) Resident #13 has had all physician visit notes placed in medical record 4) Resident #22 had BMP and CBC done on 6/30/11. DON will have reminders put on outlook calendar of quarterly and other scheduled labs to be done on resident #22 and all residents. The reminders will be set up one day prior to lab being due and day of lab due. Staff will be educated on the reminder calendars. The labs done for month will be reviewed at QA on a monthly basis until issue is resolved and then quarterly thereafter. The QA will review 1) that labs were done on timely basis and 2) that results of labs are noted and filed in charts. 5) Resident #22's BMP, Dig level and CBC done on 6/30/11 and was placed in chart. DON will have reminders put on outlook calendar of quarterly and other scheduled labs to be done. The reminders will be set up one day	for all residents including #22

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F 514	Continued From page 84 the physician saw the resident on 3/17/11 and 5/2/11. However, the progress notes were not maintained by the facility. 2. Review of the medical record showed the last physician's progress note for resident #13 was dated 3/17/11. When additional progress notes were requested on 6/28/11 at 6:30 PM, the DON was unable to produce them. She contacted the physician's office and had the progress note, dated 6/2/11, faxed to the facility on 6/29/11. 3. A request for information related to the facility's attempts to control pain for resident #13 resulted in a three hour hunt by the facility to locate the documentation. The DON finally went to the physician's office and copied the notes she had sent to him as the documentation was not found in the medical record. 4. Refer to F502 for details related to failure to complete laboratory tests as ordered for resident #22. 5. Refer to F507 for information regarding failure to file laboratory results for resident #22. 6. Review of the medical record for residents #1 and #15 failed to reveal any activity notes and assessments. Interview with the activity director on 6/30/11 at 9:10 AM revealed the notes were in her office, and should be part of the medical record. 7. Review of the medical records for residents #1 and #28 who were receiving hospice services showed the hospice plan of care was not part of the residents' records. On 6/28/11 the DON	F 514	prior to lab being due and day of lab due. The labs done for month will be reviewed at QA on a monthly basis until issue is resolved and then quarterly thereafter. The QA will review 1) that labs were done on timely basis and 2) that results of labs are noted and filed in charts. 6) All activity notes will be placed in the medical record. Activities will give all notes to Medical Records on a monthly basis to be filed. Medical Records will bring to QA a list of all residents who had activity notes placed in chart for month. This will be reported to QA until the issue is resolved and then quarterly thereafter 7) For resident #'s 1 and #28 will have coordinated care plans between hospice and the facility twice a month. The facility will either call in on conference call or be there in person with the hospice's IDT. Hospice will also attend the facilities quarterly care plan meetings. There will be a three ring binder containing the plans of care for all hospice residents and it will be kept at the nurses' station. The two care plans will work together to ensure the best for the residents. This will be done for all residents on hospice. The hospice residents care plans will be monitored on a monthly	

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F 514	Continued From page 35 called to have the documentation faxed to the facility. 8. According to physician orders, resident #22 was to receive a monthly injection of vitamin B12. Review of the medication administration records from March 2001 through June 2011 showed this was not documented as administered. On 6/29/11 at 9:45 AM the DON confirmed staff had not initialed the medication as administered, nor circled it to indicate it was not given. 9. During an interview on 6/29/11 at 10:20 AM, the DON stated the vitamin B12 monthly injection for resident #10 was discontinued in March 2011. However, review of the medical record showed no documentation of the physician's order. Further review showed staff failed to document the reason they had not administered the medication in April, May and June 2011. On 6/29/11 the DON called the physician's office to request a copy of the March 2011 order. 10. Review of the medical record for resident #45 revealed a 2/17/11 physician telephone order for "lorazepam (Ativan), 0.5 milligrams every 12 hours as needed (PRN) for agitation". Medical record review also revealed a 2/24/11 entry on the "Emissary Pharmacy Drug Regimen Review" confirming that Ativan was added to the resident's drug regimen. Further review revealed the March, April and May 2011 physician orders also listed Ativan as a current medication. However, Ativan was not listed on the June 2011 physician orders and there was no indication in the medical record when it was discontinued. Interview with RN #2 on 6/28/11 at 11:49 AM revealed she did not know when the Ativan was discontinued. Later in	F 514	basis at QA until resolved and then quarterly thereafter. 8) Resident #10 vitamin B12 was dc'd in April 2011 and reordered in July 2011. The resolution is that all residents receiving weekly, monthly etc. injections will be done on the 20th of each month and readily available. A reminder will be set up on DON's email to remind nursing staff of injections on the 18th of every month to ensure that the medication is there. Resident # 22 the MAR's were reconciled to the prescription and the Lisinoprol was made available. The MDS nurse will compare MAR's to physician orders monthly. Nurses will be in-serviced to verify all medications being administered at all med passes. Resident #32 Novalog sliding scale was corrected. It was a transcription error. The medication has been clarified and verified and put on physician orders and MAR. The MDS nurse will compare MAR's to physician orders monthly. Nurses will be in-serviced to verify all medications being administered at all med passes. All nursing staff has been counseled on the importance of verifying the prescription against the MAR. DON or designee will don monthly med pass audits. Resident #40 Preser Vision vitamins have been made available. Sunday night nurses will monitor on a weekly basis that all medications are inventoried and any	

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F 514	Continued From page 36 the day, at 2:12 PM, the RN stated she contacted the pharmacy and obtained a copy of the physician's telephone order to discontinue the Ativan, dated 2/16/11. She also stated a copy of the telephone order should have been placed in the resident's medical record.	F 514	medications that will run out that week will be faxed to pharmacy on Sunday nights. DON or designee will monitor all of the above and bring to QA on a monthly basis until resolved and then quarterly thereafter. 9) Resident # 45 Ativan was discontinued in 2/2011, the T.O. has since been placed in the medical record and MARS corrected. MDS nurse will monitor and clarify all MARS against physician orders monthly and bring findings to QA on a monthly basis until resolved and then quarterly thereafter. A new Medical Records staff was hired. Medical records QA will monitor that all physician visit notes are placed in chart compared to physician visit log. Findings will be brought to QA on a monthly basis until resolved and then quarterly thereafter.	8/15/11