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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing HRA-Human Resources Assistant MDS- Minimum Data Set ROM-Range of motion RN-Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	This facility will ensure all CNA staff has no history of abuse. This will be accomplished through state CNA registry verification 1. CNA #2, #3 & #4 will have state CNA registry queried by Personnel Department to ensure no findings of abuse are reported for these individuals. 2. Personnel Department will query the state CNA registry to ensure no findings of abuse are reported for any employed CNA. 3. Personnel Department will add state CNA registry query to employment requirements to verify all CNA's have no findings of abuse prior to employment. 4. Personnel Director will report state CNA registry queries to the Quality Assurance Committee quarterly.	9/9/11

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POC was accepted with additional corrections recieved with the administrator Joelle Claudson on 9/7/11 at 1125 KRM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joelle Claudson — TITLE: Administrator — (X6) DATE: 9/1/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility failed to verify with the state CNA registry that there were no findings of abuse for 3 of 3 CNA (#2, #3, #4) records reviewed. The findings were: Review of the personnel files for CNAs #2, #3, and #4 on 8/10/11 showed no evidence of CNA Registry verification prior to the start of employment and patient contact. During an interview with HRA #1 on 8/10/11 at 3:10 PM, she stated she was not aware of the registry or the the application process.	F 225		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and	F 244	This facility will ensure all resident grievances are promptly resolved. 1. A. Condiment trays will be refilled before the start of each meal by Dietary Staff and will remain on the table until the end of each meal. At the endof the meal Dietary Staff	9/9/11

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F 244	Continued From page 2 life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of resident council meeting minutes, the facility failed to promptly resolve resident grievances concerning the availability of condiments and assisting residents from the dining room. The findings were: 1. Review of the June and July 2011 resident council meeting minutes showed the residents had requested the condiment trays always be refilled before the start of each meal. Further, the residents were upset when staff removed these condiment trays before the end of the meal. Confidential interviews with 11 residents during the survey from 8/8/11 through 8/11/11 revealed these issues had not been addressed, and condiments were not always available. During an interview with DON #1 on 8/10/11 at 4:45 PM, she acknowledged condiments should be refilled prior to meals and condiment trays should be kept on the table until residents had completed their meal. 2. Review of the June and July 2011 resident council meeting minutes showed a concern regarding residents who were unable to leave the dining room independently after they had completed their meal. The residents, who required staff assistance for mobility, raised the concern that they had to wait for an extended period of time for staff assistance after finishing their meal. During a confidential interview with 11 residents during the survey from 8/8/11 through	F 2	will remove the trays for refilling prior to the next meal. B. CNA's will transport resident #14 out of the dining room upon request of the resident. 2. A. CNA's will observe condiment trays for refills and time on table. CNA's will report to dietary if condiments are not available to the residents during meal times so that dietary staff can immediately provide condiments to residents. B. LN's will monitor dining room and ensure all residents who request transport from the dining room are being transported from the dining room in a timely manner. 3. Dietary Manager, Director of Nursing Services and Administrator will be asked to join resident council meetings to ensure resident grievances and concerns are resolved promptly. Dietary Manager will observe dining room to ensure condiment trays are full and available to residents during their meal. Director of Nursing Services will observe dining room to ensure residents requesting transport from the dining room receive transport in a timely manner. Resident Council facility representative will report all resident concerns to appropriate departments.	

Continued F244

B. Director of Nursing Services will report resident transport requests and resultant transports to the Quality Assurance Committee quarterly..
C. Resident Council facility representative will report all resident concerns to Quality Assurance Committee quarterly.

Add: with corrective measures as appropriate 9/7/11

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F 244	Continued From page 3 8/11/11 revealed residents frequently waited up to 45 minutes for assistance to transport from the dining room. Further, they stated those residents who required assistance with eating were served after residents who ate independently, which delayed the availability of staff to assist those who had finished their meal. Interview with resident #14 on 8/10/11 at 11:15 AM revealed s/he waited 30-45 minutes after completion of his/her meal before staff was available to assist with transport. During an interview with DON #1 on 8/10/11 at 4:45 PM she acknowledged that the residents should be assisted with transport from dining in a timely manner.	F 244	Dietary staff will be inserviced by Dietary Manager regarding the need to refill condiment trays before each meal and to leave condiment trays on the table until the end of the meal. CNA's will be inserviced by DON's regarding the need to transport residents from the dining room upon request following their meal. 4. A. Dietary Manager will report dining room condiment tray observation to the Quality Assurance Committee quarterly.	
F 282 SS=D TAG	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to follow the plans of care for 3 of 9 sample residents (#5, #8, #15). The findings were: 1. Refer to F318 regarding failure of the facility to follow the plan of care for range of motion exercises for resident #5 and #15. 2. Refer to F323 regarding failure of the facility to follow the plan of care regarding environmental safety for resident #8.	F 282	This facility will ensure that services are provided in accordance with each resident's written plan of care. 1. A. Resident #5, & #15 will have Restorative Care Plan reviewed b y Care Plan team. Care Plan will be written as appropriate and Restorative Aides will be instructed to follow Care Plan for residents #5 &#15. B. Resident #8 will have Safety Care Plan reviewed by Care Plan team. Care Plan will be written as appropriate and CNA's will be instructed to provide environmental safety products for resident #8 as specified in Care Plan. 2. A. All restorative and Safety Care Plans will be	9/9/11

Continued F282

2.A. reviewed by Care Plan Team. All restorative and Safety Care Plan identified will have investigations by the DON's for implementation and documentation of Care Plan interventions. Any Intervention noted to not be in place will be put in place immediately by the Director of Nursing Services.

3. All CAN staff will be in serviced regarding the need to be familiar with the Care Plan. Cares must be provided accordingly to that Plan of Care and must be documented as cares are provided.

4. Director of Nursing Services will review Care Plans, observe CAN Restorative Care and document resident safety interventions. Results will be reported to Quality Assurance Committee quarterly by the

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE 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 medical record review and staff interview, the facility failed to ensure 2 of 4 sample residents (#5, #15) with limited ROM received adequate restorative services. The findings were: 1. Review of the medical record for resident #5 showed s/he had diagnoses which included osteoporosis. Review of the 6/27/11 significant change MDS assessment showed the resident had ROM impairment to both upper extremities. Review of the resident's care plan showed that staff identified ROM as a problem on 3/1/07 (last updated on 6/29/11), and planned for staff to work with the resident 3 times a week on ROM exercises bilaterally to upper and lower extremities. The plan required staff to document total time worked on ROM with the resident each day. The following concerns were noted: a. Review of the June 2011 restorative aide flow records showed the facility failed to document the required frequency of ROM services, as specified in the resident's care plan. The document was left blank, with no explanation given as to why staff failed to provide the ROM	F 318	This facility will 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. 1. Resident #5 & #15 will have Restorative Care Plan reviewed and Care Plan, including appropriate range of motion, will be developed. Restorative aides will be instructed to follow restorative plan of care for residents#5 & #15. 2. All Restorative Care Plans and Restorative Aide documentation will be reviewed by Care Plan team. Any residents identified as having range of motion care plans in place will have Care Plan reviewed and will have Restorative Care Plans written to include range of motion. Restorative Aides will be instructed to follow restorative plan of care for all residents. 3. Director of Nursing Service will in service all Restortive Aides regarding the need to follow the written plan of care for all residents. In service will include the need to document all cares provided by Restorative Aides. 4. Director of Nursing Services	9/9/11

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F 318	Continued From page 5 services. b. Review of the July 2011 records showed there was no documentation for ROM services provided. c. Review of the August 2011 records showed no documentation that ROM services had been performed, with one exception. On 8/8/11, there was a note that stated, "unable to do @ this time". d. During an interview with DON #2 on 8/10/11 at 1:30 PM, she stated she was not certain the resident received the required ROM services for that time frame. In addition,she verified the facility failed to document that ROM services were provided the required 3 times a week for June, July, and August 2011. 2. Review of the medical record for resident #15 showed s/he had diagnoses that included failure to thrive, chronic pain and dementia. Review of the care plan showed the resident was to receive assisted bilateral ROM services to the lower extremities and strengthening exercises for the upper extremities 3 to 5 days a week. The following concerns were identified: a. Review of the restorative aide flow sheet for July 2011 showed the resident did not receive the required ROM services as planned for 3 of 4 weeks. b. Review of the flow sheet for July 2011 showed the resident did not receive all his/her upper body extremity exercises as indicated in his/her plan of care for all 4 weeks. c. During an interview with DON #2 on 8/11/11 at 10:15 AM, she verified there were problems with the restorative program. Further, she acknowledged the care plan should have been followed by staff.	F 318	will continue a review of Restorative Services and report findings to Quality Assurance Committee quarterly. Add: If restorative care is not being carried out as scheduled corrective action will be taken. KB 9/7/11	

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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, medical record review and staff interview, the facility failed to ensure a safe sleeping environment for 1 of 1 sample residents (#8). The findings were: Medical record review for resident #8 showed s/he had diagnoses that included anoxic (absence of oxygen) brain damage, involuntary movement and epilepsy. Review of the resident's care plan showed s/he was to have padded head and footboards to prevent injury. During random observations on 8/9/11-8/11/11, while the resident was in bed, the padding at the foot of the bed was observed dangling from the footboard. Interview with RN #1 on 8/10/11 at 2:50 PM revealed the resident had kicked the padding off of the footboard. Further, the resident had a history of kicking staff due to his/her diagnoses. Interview with DON #2 on 8/11/11 at 10:15 AM revealed the resident needed the padded footboard. In addition, the facility was looking for alternatives to the padding currently being used.	F 323	This facility will ensure that the resident environment remain as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident #8 will have Care Plan review by Care Plan Team. Review will include safety precautions. Care plan will be written to reflect safety needs of resident #8. Director of Nursing Services will work with appropriate staff to ensure all determined safety measures are implemented. 2. All residents safety Care Plans will be reviewed by Care Plan Team. Care plans will be written as appropriate and Director of Nursing Services will work with appropriate staff to ensure any resident with identified safety needs has safety precautions implemented immediately. 3. Director of Nursing Services will in service staff regarding the need to follow Safety Care Plans as written. 4. Director of Nursing Service will continue a review of resident safety interventions	9/9/11
F 323				
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332	This facility will ensure that it is free of medication error rates of five percent or greater.	9/9/11

Continued F323

and report findings to Quality Assuranc Committee quarterly.

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F 332	Continued From page 7 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 and staff interview, the facility failed to maintain a medication error rate under 5 percent (%). Three medication errors were observed out of 40 opportunities for error, which resulted in an error rate of 7.5%. The findings were: a. During an observation on 8/9/11 at 11:40 AM, RN #1 prepared medications, including sucralfate (gastrointestinal agent) 1 gm, for administration to resident #13. The medication label stated to administer before meals. The medication was administered in the dining area, and the resident proceeded to eat breakfast within five minutes of the medication administration. b. Observation on 8/9/11 at 11:35 AM showed DON #1 gave resident #14 sucralfate 1 gm in the dining room. The medication label stated it was to be given before meals. The resident started eating ten minutes after medication administration. c. Observation on 8/9/11 at 11:40 AM showed DON #1 gave resident #19 sucralfate 1 gm in the dining room. The medication label stated it was to be given before meals. The resident started eating five minutes after medication administration. d. During an interview with DON #1 on 8/9/11 at 11 AM, she stated that sucralfate should be administered one hour before meals. findings we	F 332	1. All LN's will be instructed that residents # 13, #14 & #19 are to be given sucralfate one hour before meals with water. Director of Nursing Services will observe all LN's during med pass for residents #13, #14 & #19 to ensure medication is given appropriately. 2. Director of Nursing Services will observe all LN's during all resident med pass to ensure all medication is given appropriately. 3. Director of Nursing Services will in service staff regarding the appropriate medication delivery and the necessity to follow medication guidelines. 4. Director of Nursing Services will continue a review of resident medication passes and report findings to Quality Assurance Committee quarterly. change observations' by DON to: All LN's will be observed random 4 times/week. observed inaccuracies will result in an increase in observations KR 9/7/11 If inaccuracies are observed during med pass, corrective action will be immediately taken. KR 9/7/11	

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F 332	Continued From page 8 According to Lexi-Comps Drug Information Handbook for Nursing 2010, sucralfate should be administered with water on an empty stomach one hour before or two hours after meals.	F 332	This facility will practice acceptable infection control practices. 1.A. CNA #1 will be instructed by DON's regarding appropriate feeding procedures between residents. B. CNA #1 will be instructed by DON's regarding appropriate peri-care infection control technique. 2. Director of nUrsing Services will observe all CNA's during resident feeding and peri-care for appropriate infection control technique. DON's will immediately instruct staff as infection control inaccuracies are noted. 3. Infection Control Coordinator will inservice staff regarding appropriate infection control technique during resident feeding and cares. 4. Director of Nursing Services will continue a review of CNA cares and feeding of residents. Results wil bereported to Quality Assurance Committee quarterly.	9/9/11
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, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		
F 332	(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			

Change frequency of observations by DON to: All CNAs will be randomly observed 3 times/week. Observed inaccuracies will result in an increase in observations
KAN 9/7/11

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F 441	Continued From page 9 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 and staff interview, the facility failed to practice acceptable infection control practices while assisting 1 sample resident (#5) and 1 non-sample resident (#20) during two random observations. The findings were: 1. Observation on 8/9/11 at 8:20 AM showed CNA #1 sitting at the assisted dining table between residents #5 and #20. The CNA was hand feeding bacon and wiping resident #5's mouth, then assisted resident #20 with his/her drinking straw. As she assisted resident #20, she touched the resident's wheel chair and straightened his/her clothing. The aide did not cleanse her hands at any time during the observation. Interview with the CNA on 8/10/11 at 1:20 PM revealed she understood she needed to cleanse her hands between residents but had run out of her hand sanitizer. 2. Review of the 6/27/11 significant change MDS assessment showed resident #5 needed significant assistance with toileting. During an observation on 8/9/11 at 9 AM, CNA #1 prepared to provide incontinence care to the resident. The aide soaked multiple washcloths with water in the resident's sink, used for handwashing and personal care, without first disinfecting the sink. The aide then provided incontinence care, and	F 441		

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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 10 cleansed a stage III decubitus on the resident's left coccyx with the washcloths. Interview with the aide immediately after the observation revealed she should not have placed the washcloths in the sink, but should have used a clean basin.	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to maintain an effective pest control program for flies in a variety of resident areas. The findings were: During the initial tour on 8/8/11 at 4 PM, flies were observed in individual resident rooms and the common areas. On 8/9/11 at 11 AM, observation showed residents had been given fly swatters to use in their rooms. During confidential interviews with 11 residents from 8/8/11 through 8/11/11, they revealed the flies were a problem. In addition, the residents felt it was something they would have to tolerate due to the time of year. Interview with maintenance staff #1 on 8/11/11 at 9 AM revealed the facility had fly traps on the patio area and loading dock but had not asked the contracted pest control agency to assist with the problem. He also stated staff stand with the door opened during conversations and the night staff prop open the door when they go outside.	F 469	This facility will maintain an effective pest control program so that the facility is free of pests and rodents. 1. Maintenance staff will contact pest control provider to provide assistance with pest problem. 2. Reccomendations of pest ocntrol provider will be implemented. 3. Maintenance staff will observe facility for pest control issues throughout the year and contact pest control provider as appropriate. 4. Safety Officer will add pest control issues to facility observation schedule and report results to Quality assurance Committee quarterly.	9/9/11