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

PRINTED: 07/05/2005
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
	535021	A. BUILDING _____ B. WING _____	06/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 HWY 20 SOUTH BASIN, WY 82410

RECEIVED
JUL 27 2005
DEPT OF HEALTH FACILITY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy and procedure review, and medical record review, the facility failed to notify a physician of blood sugar changes for one (#38) of six sample residents with	F 157		

COPY

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

Michelle Watson — Assistant Facility Manager — 7-14-05

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 157	Continued From page 1 diabetes. The findings were: Review of the diagnosis report revealed resident #38 was admitted with a diagnosis of diabetes. Review of the resident's documented blood sugar levels revealed this resident had fluctuating blood sugars ranging from a low of 50 mg/dL (milligrams per deciliter) to a high of 184 mg/dL. Review of the 3/1/05 physician's orders revealed staff were to notify the physician if the resident's blood sugar was less than 70 mg/dL or greater than 350 mg/dL. Review of the resident's vital report document revealed the resident's blood sugar levels were below 70 mg/dL 13 times between 3/1/05 and 6/13/05. Review of the entire medical record revealed the physician was not notified of the following: a. blood sugar level of 50 mg/dL at 8:30 PM on 3/7/05. b. blood sugar level of 68 mg/dL at 4:30 PM on 4/18/05. c. blood sugar level of 61 mg/dL at 4:30 PM on 4/19/05. d. blood sugar level of 59 mg/dL at 4:30 PM on 4/20/05. e. blood sugar level of 62 mg/dL at 6:30 AM on 4/22/05. Review of the facility's policy entitled "Diabetic Blood Sugar Monitoring," which was revised on 2/22/05, revealed "If the physician has given specific parameters for the resident, notify [the] physician of any abnormalities on [the] next business day if [the] resident exhibits no signs and symptoms of hypo/hyperglycemia. Abnormal blood sugar readings with clinical signs/symptoms of hypo/hyperglycemia are to be reported to the physician, or his alternate, immediately." Interview with the acting director of nurses on 6/16/05 at 12 noon confirmed the physician	F 157	F157 Notification of Rights and Services The correction of this tag will be accomplished as follows: All blood glucose readings for resident #38 that are either under 70 or over 350 will be reported to the resident's physician as per doctor's order. All residents with the diagnosis of diabetes are at risk. The nurse manager has spoken directly to those nursing staff who failed to report abnormal blood glucose readings to the physician. She is also conducting ongoing in-service education with nursing staff. The nurse manager, or her designee, will be responsible for overseeing resident care. A random sampling of a minimum of six resident charts will be audited quarterly for compliance. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	8/5/05 7/12/05

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F 157	Continued From page 2 should have been notified of the abnormal blood sugar levels.	F 157		
F 250 SS=D	483.15(g) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview the facility failed to ensure that one non-sample resident who was being prepared for discharge to an independent setting, was capable of self-administering medications. The findings were:	F 250	F250 Social Services The correction of this tag will be accomplished as follows: Resident #33 has been discharged. Prior to the discharge a locked security box was purchased by WRC to store medications during the trial period of self administration of medications. The resident was determined to be successful at self administration. All residents with the potential to be discharged are at risk to be affected.	6/28/05
	During observation of a medication pass on 6/15/05 at 4:50 PM, licensed practical nurse (LPN #1) administered medications to resident #33. Interview on 6/16/05 at 10:30 AM with resident #33 revealed the social service designee was making arrangements for the resident to move into an apartment complex. The resident stated he/she was under the impression the move would occur sometime in July 2005. When questioned about self-administering of medications, the resident stated the social service designee (SSD) had never discussed the matter as part of living independently. Interview with the SSD on 6/16/05 at 10:45 AM confirmed he was working with the resident regarding discharge to an apartment in the community. Further interview at that time revealed the SSD had failed to recognize the need for the resident to self-administer as a key component to ensure he/she could live in an		The social service director, as well as the entire discharge planning team, has been instructed in the process of assessment of readiness for self administration of medications prior to implementation of the self administration trial period within the facility. The nurse manager/designee is responsible for monitoring any self administration medication program for residents. She, or her designee, will be required to be present at any discharge planning meetings to assure compliance with all aspects of discharge planning. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	6/29/05

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F 250	Continued From page 3 unsupervised setting. Review of the facility policy regarding self-administration of medications showed that one of the purposes was to provide a method of assessment to determine if a resident was capable of self-administration.	F 250		
F 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to ensure a clean, orderly, and sanitary environment in several areas for resident use. The findings were: 1. Observation of the north unit on 6/16/05 at 8:20 AM revealed the following concerns: a. There was an accumulation of dirt and grime around the doorways into resident rooms, utility rooms and the medication room. b. There was an accumulation of dirt and grime underneath the double doors leading to the library and underneath the double doors leading to the day room. c. There was a large spot of accumulated dirt and a large dark brown stain in the entryway to resident room 212. 2. Observation of the north special care unit on 6/16/05 at 8:30 AM revealed the following concerns: a. There were ten pieces of dirty tape,	F 253	F 253 Environment of Care The dirt around the doorways is an area which the commercial cleaning machines cannot reach. This type of cleaning is now being done by hand. Doorways into resident rooms, utility rooms, medication rooms, library and day room will be thoroughly cleaned. The entryway into Room #212 will be cleaned. The floor tape in the Special Care unit across from Room #227, which had been used for bowling activity, has been removed. The top of the refrigerator in the closet, Room 229, has been cleaned of cracker crumbs.	8/5/05 7/05/05 7/05/05

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F 253	Continued From page 4 measuring approximately 1 inch by 3/4 inch in the middle of the floor, across from resident room 227. b. There was an accumulation of cracker crumbs on top of the refrigerator located in room 229. 3. Observation of the north smoking room on 6/16/05 at 8:45 AM revealed the following concerns: a. There were two floor mats discolored by smoke. b. There was a strong smoke odor permeating the room. c. The ceiling vent was covered with dirt and grime. d. The walls were stained from cigarette smoke. e. The window was dingy and covered with smoke residue. Interview on 6/14/05 at 9 AM with resident #54 revealed he/she thought the smoking area smelled bad. 4. On 6/15/04 at 2 PM observation of the smoking room on the south unit revealed the following concerns: a. Two plastic floor mats were dark brownish/black and covered in cigarette burns. Interview with the maintenance man on 6/15/05 at 2:40 PM revealed the mats were originally light cream in color. b. The yellow walls were stained from smoke. c. The windows were dingy and coated with cigarette smoke residue. d. The tile floor was stained and had numerous black scuff marks and scrapes. e. When the door to the smoking room was opened, the odor wafted into the main corridor	F 253	F253 Environment of Care – continued The floor mats in the smoking rooms have been removed. The ceiling, walls, vents, fans and windows have been cleaned and will continue to be cleaned weekly. The floors and ashtrays have been cleaned and are being cleaned daily. 7/14/05 A room air filtering device is being reviewed for purchase to help control the smoke odor. 8/5/05 The microwave in the activities area has been cleaned. 7/13/05 The defibrillator, aspirator and suction machines have all been cleaned. 7/13/05 All doorways in the facility have the potential to become soiled. All refrigerators in the facility have the potential to become soiled. Both north and south smoking rooms will continue to be used on a daily basis and have the potential to become soiled and/or smell of smoke. All microwaves in the facility have the potential to become soiled. Any equipment which is used on an infrequent basis has the potential to become dusty and/or soiled. This equipment will be kept covered.	

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F 253	Continued From page 5 and lingered for about 15 minutes. In addition, the odor was such that LPN #2 gave housekeeper #1 a mask to wear while cleaning the room. f. Interview on 6/15/05 at 2:40 PM with maintenance man #1 revealed there were at least five residents on the south unit who used that particular smoking room. 5. Observation of the south unit on 6/16/05 at 9:15 AM revealed there was an accumulation of dirt and grime around the doorways into resident rooms, utility rooms, and the medication room. 6. Observation of the activity room on 6/16/05 at 9:35 AM revealed there was a microwave used for resident food. Observation of the interior of the microwave revealed brown colored stains and food particles on the top and bottom. 7. Observations on 6/13/05 at 6:30 PM at the north and south nurses' stations revealed an aspirator and a defibrillator. Both were coated with a heavy accumulation of dust. 8. Observation on 6/14/05 at 8 AM revealed a suction machine in the far left corner of the main dining room. There was excessive dust build-up on the throat evacuation box, along with a bottle of sterile water that had expired on 12/04.	F 253	F253 Environment of Care – continued Housekeeping department is primarily responsible for cleaning in the facility. Nursing personnel and/or individual staff in each resident care area will assist as needed in isolated incidents. A "walkabout" checklist will be given to the department managers monthly and they will work in pairs to monitor the cleanliness of specified areas. Results will be reported to the director of housekeeping who will assign cleaning tasks as necessary. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	
F 272 SS=E	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		

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F 272	Continued From page 6 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 272		

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F 272	Continued From page 7 and staff interview, the facility failed to complete comprehensive assessments in various areas for 6 of 16 sample residents (#18, #38, #45, #58, #60, #63, #64) who required those assessments. The findings were: 1. Observation on 6/14/05 at 10:56 AM showed resident #45 was confined in a wheelchair with a grey belt which crossed his/her lap and looped over prongs that were located in the back of the wheelchair. The belt lacked a self-releasing buckle and kept the resident restrained. Review of the 2/21/05 admission Minimum Data Set (MDS) assessment revealed the resident was severely cognitively impaired, received antipsychotic medications, and did not require restraints. According to the physician's orders, the resident received Zyprexa (antipsychotic) 2.5 milligrams (mg) since 11/10/04 and utilized a grey loop belt restraint since 4/19/05. Review of the assessment information listed in Section V for the aforementioned MDS assessment showed a comprehensive assessment related to the antipsychotic medication was lacking. In addition, the medical record lacked an evaluation which addressed the safety of the belt and whether it was the least restrictive restraining device. Interview with the MDS coordinator on 6/15/05 at 4 PM confirmed lack of comprehensive assessments for the antipsychotic medication and restraints. 2. Review of the physician's orders revealed resident #58 received Seroquel (antipsychotic) 100 mg twice a day since 6/15/04. Review of the 10/29/04 annual MDS assessment confirmed the resident triggered for use of an antipsychotic medication and required further assessment.	F 272	F272 Resident Assessment – Comprehensive Assessment The correction of this tag will be accomplished as follows: Comprehensive resident assessments for chemical/physical restraints will be completed for residents #45, #58, #84, #60 and #38 as part of the MDS assessment. All residents on chemical/physical restraints are at risk. The MDS coordinator, under the direction of the nurse manager, is responsible for the completion of assessments of all residents. The medical records supervisor will prepare a random monthly report of all residents receiving antipsychotic and/or psychotropic medications and physical restraints. The medical records of those residents will be reviewed by the nurse manager or her designee to assure that a comprehensive assessment for the antipsychotic medication and/or physical restraint was completed. The policy and procedure on restraints will be in-serviced to all staff by the MDS and training coordinators. Before any restraint is implemented, the nurse manager/designee will be notified to assure that the family, physician, and resident have all been involved in the decision and the appropriate least-restrictive device implemented. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	8/5/05

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F 272	Continued From page 8 However, according to the information included with that MDS assessment, the only reason the resident received the medication was for a diagnosis of Alzheimer's disease. Interview with the MDS coordinator on 6/15/05 at 4 PM confirmed lack of a comprehensive assessment which identified the causative and contributing factors for use of the antipsychotic medication. 3. Review of the 5/27/05 annual MDS assessment showed resident #64 triggered for use of an antipsychotic medication and required further assessment. Review of the physician's orders confirmed the resident received Seroquel 12.5 mg since 1/18/05. According to the 5/27/05 evaluation for use of the antipsychotic medication, the resident received it for dementia and a diagnosis of psychosis. No further assessment information was provided. Interview with the MDS coordinator on 6/15/05 at 4 PM confirmed lack of a comprehensive assessment explaining why the antipsychotic medication was appropriate for the resident. 4. Review of the June 2005 physician orders for resident #18 revealed he/she had been on Risperdal (antipsychotic) 2 mg since admission on 3/28/05. According to the resident's 4/8/05 admission MDS assessment, the resident was identified as receiving an antipsychotic drug. However, review of the 4/8/05 Resident Assessment Protocol (RAP) summary showed the area to address psychotropic drug use was blank. As a result, a comprehensive assessment addressing the use of this drug was not performed. 5. Review of the June 2005 physician's orders for resident #63 revealed he/she received Seroquel	F 272		

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F 272	Continued From page 9 50 mg since 12/20/04. According to the resident's 1/7/05 14 day MDS assessment and the 4/8/05 quarterly MDS assessment, the resident was identified as receiving an antipsychotic drug. However, review of the 1/7/05 RAP modules, revealed use of Seroquel was not addressed. As a result, a comprehensive assessment addressing the use of this drug was not done. 6. Review of the physician's progress notes revealed resident #60 was admitted with diagnoses including obsessive compulsive disorder, and schizophrenia. Review of the December 2004 physician's orders revealed orders for Thorazine (antipsychotic) 25 mg three times daily, Zyprexa 15 mg daily, Xanax (antianxiety) 0.25 mg daily and 0.5 mg as needed, and lithium (antipsychotic) 300 mg twice daily. Review of the medical record, including social service notes and all assessments, revealed there was no comprehensive assessment for psychotropic medications. 7. Review of the diagnosis report revealed resident #38 was admitted with diagnoses including bipolar disease. Review of the April 2005 physician's orders revealed an order for Seroquel 50 mg daily. Review of the medical record, including social service notes and all assessments, revealed there was no comprehensive assessment for psychotropic medications.	F 272		
F 280 SS=D	483.20(k)(2) RESIDENT ASSESSMENT A comprehensive care plan must be: Developed within 7 days after the completion of the comprehensive assessment;	F 280		

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F 280	Continued From page 10 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, record review, and staff interview, the facility failed to revise care plans for 2 of 16 sample residents. Residents #37 and #63 did not have an updated care plan to address current toileting needs. The findings were: 1. During observation on 6/15/05 at 8:55 AM, resident #37 refused toileting and was assisted to bed. Further observation at 10:30 AM revealed the resident was continent of urine. Review of the resident's toileting plan for the day shift showed he/she was to be toileted every two to two and one half hours. Interview with certified nurse aide (CNA) #2 at 10:45 AM revealed this plan was not current. Instead, the resident was toileted before breakfast and before lunch. The CNA also stated the resident was able to let staff know when he/she needed to use the toilet. 2. Observation on 6/16/05 at 10:30 AM revealed resident #63 was continent of urine. Review of the resident's toileting care plan showed the resident was to be toileted between 6:30 AM and 9 AM, between 11 AM and 11:30 AM, and between 1:30	F 280	F280 Resident Assessment – Revision of Care Plans A revised care plan will be completed for Residents #37 and #63 re toileting issues. All residents with toileting needs are at risk if care plans are not updated as their toileting needs change. The MDS coordinator and bowel and bladder nurse, under the direction of the nurse manager, are responsible for the resident care plan as part of the MDS process. The nurse manager will review the current care planning process. A minimum of 6 resident care plans will be reviewed monthly by the nurse manager/designee for accuracy and completeness. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	8/5/05

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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
	535021	A. BUILDING _____ B. WING _____	06/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	990 HWY 20 SOUTH BASIN, WY 82410

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F 280	Continued From page 11 PM and 2 PM. Interview with CNA #2 on 6/15/05 at 8:55 AM revealed this plan was not current. Instead, the resident was toileted before breakfast and before lunch. The CNA further stated, that when asked, the resident was able to tell staff if he/she needed to use the toilet. Interview on 6/15/05 at 10:50 AM, with the licensed practical nurse (LPN) responsible for the facility's bowel and bladder program verified the toileting care plans for resident's #37 and #63 were not current.	F 280		
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure staff followed professional standards of practice. Licensed staff left medications unattended or unlocked and administered an incorrect dose of Tegretol to Resident #41. The findings were: 1. During observation on 6/15/05 at 4:50 PM, licensed practical nurse (LPN #1) administered Tegretol (anti-seizure) 300 mg (three 100 mg tablets) to resident #41. When LPN #1 went to dispense the evening dose of Tegretol, he/she found that one of the three tablets still remained in the AM portion of the bubble pack. The LPN closed that portion of the bubble pack with tape, and noted that only 200 mg had been given that AM instead of 300 mg. Review of the June 2005 physician's orders showed the morning dose of	F 281		

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

PRINTED: 07/05/2005
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 12 Tegretol was 300 mg. 2. Observation on 6/13/05 at 5:34 PM showed licensed practical nurse (LPN) #4 administered medications including Depakote (anticonvulsant also used to control manic episodes associated with bipolar disorders) and Lorazepam (sedative/hypnotic) to resident #30. However, the LPN set the medication cup on the dining room table, turned, and walked away without watching to see if the resident actually took the medications. On 6/16/05 at 12:10 PM, review of the resident's care plan with LPN #2 revealed the resident was not care planned for self-administration of medications. During the review, the LPN stated the resident had a "very short" short term memory and staff must watch to be sure the resident swallowed medications. In addition, observation on 6/13/05 at 5:34 PM showed LPN #4 left the medication cart unlocked when she administered medications to the resident. The LPN had no visual contact of the cart for 15 seconds, and several residents were seated next to it. Furthermore, many residents were coming into the dining room for the evening meal. 3. During observation on 6/14/05 at 9:50 AM, LPN #2 left the medication cart unattended with a bottle of multivitamins, a bottle of Vitamin B, and an inhaler on top of it. During this time period observation showed residents in the area of the medication cart.	F 281	F281 Resident Assessment – Professional Standards of Quality The professional standards for administration of medications to residents #41 and #30 will be reviewed by the nurse manager with the individual nurses who were involved in this deficiency. The nurse educator will present an in-service on passing medications to all professional nursing staff. All residents are at risk for medication errors. All licensed professionals are responsible for the safe administration of medications to residents. The nurse manager/designee will do a medication pass observation quarterly to include at least two shifts on each of the nursing units. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	8/5/05 8/5/05
F 282 SS=D	483.20(k)(3)(ii) RESIDENT ASSESSMENT The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		

PRINTED: 07/05/2005
FORM APPROVED
OMB NO 0938-0391

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

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F 282	Continued From page 13 care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of facility policies and procedures, the facility failed to ensure correct implementation of the care plan for 1 (#61) of 16 sample residents. The findings were: Review of the diagnosis report revealed resident #61 was admitted with diagnoses including peripheral vascular disease. Review of the May 2005 physician's orders revealed an order for daily Jobst pressure stocking treatment, at 40 to 50 pounds of pressure, for twenty minutes to each leg. Observation on 6/14/05 at 8:50 AM revealed a certified nurse aide (CNA#5) placed the Jobst stocking on the resident's left leg. Further observation revealed CNA #5 set the dial at 32 pounds of pressure. When asked by the surveyor how she knew where to set the dial, the CNA stated it was on the restorative physician order flow sheet. Review of that flow sheet revealed the dial should have been set at 40-50 pounds of pressure instead of 32 pounds of pressure. Interview with the acting director of nurses on 6/16/05 at 12 noon confirmed the pressure should have been set as written on the restorative physician order flow sheet, which was based on physician orders.	F 282	F282 – Resident Assessment – Implementation of Care Plan The nurse manager has reviewed the proper settings for Jobst pressure stockings for resident #61, as per physician order, with the supervising restorative/functional maintenance nurse. The nurse educator will present an in-service on the proper application of Jobst pressure stockings to all professional nursing staff. All residents are at risk if such equipment is ordered by the physician. The restorative/functional maintenance nurse will review the policy and will be responsible for the application of the Jobst Pressure Stocking. The nurse manager is ultimately responsible for all resident care provided in the facility. The restorative/functional maintenance nurse will check the pressure settings specified by the physician orders against the pressure settings which are set on the equipment. Results will be reported to the nurse manager and at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	7/13/05 8/5/05
F 312 SS=D	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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

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FORM APPROVED
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F 312	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and medical record review, the facility failed to assure staff provided good personal hygiene during three of five observations of perineal care for residents #45, #48, #61 who required staff assistance. The findings were: 1. According to the facility's January 2002 policy and procedure, "Perineal Care," staff should cleanse the perineal area by "wiping from front to back." In addition, according to the critical element steps in the November 2001 "Nurse Aide Written (or Oral) Examination and Skills Evaluation Candidate Handbook," staff should use a clean area of the wipe with each stroke when providing perineal care. Inclusion of the critical element steps was identified as necessary to pass the skills test. The following concerns related to lack of implementation of this skill were identified: a. Review of the 2/21/05 admission Minimum Data Set (MDS) assessment revealed sample resident #45 required total staff assistance with toileting and hygiene. On 6/14/05 at 8:42 AM observation showed a staff member assisted resident #46 to the toilet. Although the resident was continent, the staff member provided perineal care by cleansing the resident with a back and forth motion from the buttocks to the anterior perineal area. In addition, the staff member used the same area of the perineal wipe while cleansing the resident. b. Observation on 6/14/05 at 9:38 AM showed a staff member assisted non-sample resident #48 to the toilet. The resident was continent of urine but required staff assistance with perineal care.	F 312	F312 – Quality of Care – Personal Hygiene The correction of this tag will be accomplished as follows: The nurse manager has presented an in-service on proper perineal care to all nursing assistants and physical therapy assistants. She will continue to provide reminders at monthly staff meetings. All residents receiving perineal care are at risk of infection due to improper procedures. The nurse manager/designee will observe six aides on each shift providing perineal care each quarter. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	6/28/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 312	Continued From page 15 When the staff member provided that assistance, she cleansed the resident using a back and forth motion with the same area of the perineal wipe. Interview with the acting director of nursing (ADON) on 6/16/05 at 2:30 PM confirmed providing perineal care with a back and forth motion was not acceptable. 2. Review of the 5/13/05 annual MDS assessment revealed sample resident #61 was incontinent and dependent on staff for perineal care. According to the current care plan, staff were to provide perineal care for the resident after each incontinent episode. Observation on 6/14/05 at 11:15 AM revealed the resident's incontinence brief was wet with urine. Observation further revealed a staff member did not cleanse the anterior perineal area, which was damp with urine, prior to placing a clean brief on the resident. Interview with the ADON on 6/16/05 at 12 noon revealed the staff member stated she/he had "forgotten" to do proper perineal care.	F 312		
F 318 SS=D	483.25(e)(2) QUALITY OF CARE 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, staff interview, and review of facility policies and nursing schedules, the facility failed to consistently provide range of motion services for	F 318		

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

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OMB NO. 0938-0391

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F 318	Continued From page 16 two of eight sample residents (#45, #64) with limited range of motion and/or loss of voluntary movement. The findings were: 1. According to the 2/21/05 admission Minimum Data Set (MDS) assessment, resident #45 had severely impaired cognition. Review of the restorative evaluation for the 4/6/05 Medicare assessment showed the resident had partial loss of voluntary movement in one leg and foot. According to the physician's orders dated 4/12/05, the resident was on the restorative nursing program (RNP) and staff were to provide lower extremity exercises six times a week. Further review of the orders showed the frequency of the program was decreased to three times a week on 5/12/05. According to the facility's policies and procedures related to the restorative nursing program, the purpose of the program was to "perform restorative nursing therapy as prescribed..." Review of the RNP documentation for April and May 2005 showed staff provided the program for the resident 10 times from April 12th through April 30th and 6 times from May 1st through May 12th, a total of 16 times out of 26 opportunities. After the exercise program was changed to three times a week on 5/12/05, review of the RNP documentation showed staff failed to provide the program twice from 5/12/05 through 6/14/05. Interview with the restorative nurse on 6/15/05 at 9:25 AM confirmed the restorative nursing program was not provided as ordered. 2. Review of the 3/4/05 quarterly and 5/27/05 annual MDS assessments showed resident #64 had severely impaired cognition and bilateral limitations in range of motion with partial loss of voluntary movement in the arms, hands, legs, and	F 318	F318 – Quality of Care – Range of Motion The restorative care provided to residents #45 and #64 has been reviewed by the nurse manager to verify that a problem occurred. The care provided did not meet the frequency ordered by the physician. All residents who receive restorative care are at risk. The restorative program is being reviewed to ensure that residents receive appropriate restorative care in a timely manner, as ordered by the physician. The nurse manager will meet with the restorative nurse to review the program and make adjustments as necessary to assure compliance with physician orders. The nurse manager will report the results of the meeting and any pertinent findings at the quarterly Quality Assurance meeting as reviewed by the Medical Director.	6/16/05

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 318	Continued From page 17 feet. Observation on 6/14/05 at 9:40 AM showed the resident received an exercise program. Review of that program revealed the resident was on a functional maintenance program (FMP) three times a week. However, review of the FMP documentation for March, April, May, and June 2005 showed the facility failed to provide the program once in March, three times in April, and three times in May. Furthermore, as of June 13, 2005, the program was only provided three times out of six possible opportunities. Although review of the facility's policies and procedures related to the restorative program showed the job description for the restorative aide included "Conduct therapy regimens as instructed...", interview with restorative aide (RA) #1 on 6/14/05 at 9:40 AM confirmed the documentation was accurate and the program was not always provided as instructed due to being "short staffed." 3. During confidential interviews between 6/13/05 and 6/16/05, a staff member stated she might not be pulled from the restorative program, but she had to cover other areas when someone else was pulled. A second staff member also stated the restorative staff were pulled to provide care elsewhere when the facility was short staffed. The second staff member stated there was one restorative nurse, two RAs, and a total of 48 residents who were on either the functional or restorative programs. When either the restorative nurse or the RA was pulled elsewhere, the remaining staff had to pick up extra residents. When this happened the FMP was dropped to provide the RNP. Review of the nursing schedules for June 2005 confirmed the restorative staff were assigned other duties.	F 318		

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

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F 323	Continued From page 18	F 323	F323 – Quality of Care-Safe Environment	
F 323 SS=D	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe environment. The findings were: 1. During tour of the north unit on 6/16/05 from 8:20 AM to 9:15 AM the following safety concerns were identified: a. There was a razor plugged into the wall socket lying on the handrail outside room 241. b. There was a bottle of hand sanitizer (identified as hazardous material) on the handrail outside room 243. c. There was an outlet faceplate located towards the back wall next to the window in the smoking room that was crooked, exposing two exposed metal plates. 2. Observation of the north shower room on 6/16/05 at 9 AM revealed it was unlocked and the door was standing open. The following concerns were identified: a. There were three straight edge razors lying on shelf areas accessible to residents. b. There was one bottle with a Sysco label that contained a chemical compoind and two bottles of body wash with hazardous warning labels; all three bottles were on shelves which were accessible to residents. Interview with CNA #3 on 6/16/05 at 9:10 AM revealed the shower room door was supposed to	F 323	The correction of this tag has been accomplished by the following: The outlet faceplate in the smoking room has been repaired. The electric razor located outside of Room #241 has been removed, as was the mislabeled bottle of hand sanitizer. The safety razors have been moved to the locked cabinet in the bathing area. The bathing aides have been reminded to keep the bathing area locked when they are not in direct attendance. All residents are at risk in an unattended bathing area. The nurse manager has spoken directly with the bath aides who were responsible for the above problems. Maintenance has been instructed on the importance of checking faceplates and electrical outlets on a regular basis to identify and correct problems. A "walkabout" checklist will be given to the department managers monthly and they will work in pairs to monitor the safety of a specified area. Results will be reported to the nurse manager and director of maintenance for appropriate action. The results will then be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	6/16/05 6/20/05 6/20/05

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F 323	Continued From page 19 be kept closed and locked.	F 323		
F 353 SS=E	483.30(a)(1)&(2) NURSING SERVICES The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses; and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, confidential interviews with residents and staff, and review of facility policies and nursing schedules, the facility failed to provide sufficient staff to provide timely care and services for residents. The findings were: 1. During confidential interviews between 6/13/05 and 6/16/05, a staff member stated she might not be pulled from the restorative program, but she	F 353		

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

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F 353	Continued From page 20 had to cover other areas when someone else was pulled. A second staff member also stated the restorative staff were pulled to provide care elsewhere when the facility was short staffed. The second staff member stated there were one restorative nurse, two restorative aides (RAs), and a total of 48 residents who were on either the functional maintenance or restorative nursing programs. When either the restorative nurse or the RA were pulled elsewhere, the remaining staff had to pick up extra residents. When this happened the functional maintenance program was dropped to provide the restorative nursing program. Review of the nursing schedules for June 2005 confirmed the restorative staff were assigned other duties. Refer to F318 for information related to lack of services for residents with restorative needs. 2. During a confidential staff interview between 6/13/05 and 6/16/05, a staff member stated there was frequently a staffing shortage. The staff member stated that during those times, care had to be prioritized to keep residents dry. He/she further stated the care needs not done included repositioning, turning, and getting residents up in chairs or wheelchairs. Observations on 6/14/05 at 4:45 PM and on 6/16/05 at 9 AM revealed only two CNAs were on the north unit to care for 34 residents. 3. A confidential staff interview between 6/13/05 and 6/16/05 revealed there was an ongoing staff shortage. The staff member stated extra help was called in because of the "state" survey but usually there was not enough staff to meet resident needs. 4. During a confidential interview between 6/13/05	F 353	F353 – Nursing Services – Staffing Staffing ratios and assignments of duties are being reviewed by the nurse manager for appropriateness. All residents are at risk if staffing levels are not appropriate. Two nursing supervisor positions have been reclassified to staff positions to enhance nursing coverage. A second activities person has recently been hired which will shift an aide from the activities department back into a direct care nurse aide position. A certified nurse aide class is now in progress with cooperation between Northwest Community College in Powell, WY and Worland Care Center in Worland, WY. We continually advertise to fill these vacant positions. The nurse manager/designee will calculate PPDs randomly and communicate this data to the administrator so that problems or trends can be identified and corrected. As necessary, results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	8/05/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER'S FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	06/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	890 HWY 20 SOUTH BASIN, WY 82410

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F 353	Continued From page 21 and 6/16/05, a staff member stated the facility was unable to use their waiver to provide the certified nurse aide (CNA) course as they were not allowed to pay someone to teach the class. 5. Interview with the acting director of nursing (ADON) on 6/14/05 at 3:35 PM confirmed the facility was short staffed since they had two licensed nurses and six CNAs who were unable to work as of that date. During the interview, the ADON stated staff were working overtime to provide as much coverage as possible. 6. During an interview on 6/16/05 at 11 AM, the facility's administrator stated that more staff needed to be hired. He further stated many of the staff were working long hours and extra shifts to ensure adequate coverage on the nursing units. As a result, staff absences from work-related injuries had increased.	F 353		
F 371 SS=D	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure refrigerated supplements were properly labeled and discarded when out-dated. The findings were: On 6/16/05 at 8:30 AM observation of the refrigerator in room 229 on the north special care unit revealed a thawed 4 ounce Resource Health Shake for resident #45 that was undated. Observation of the north unit refrigerator located	F 371		

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F 371	Continued From page 22 at the nurses' desk on 6/16/05 at 9:05 AM revealed eight 4-ounce cartons of Resource Health Shakes which were thawed and undated. Interview with RN #1 at this time revealed he/she was unaware of the date the shakes were thawed. Interview with the dietary manager on 6/16/05 at 3:05 PM revealed the shakes should have been labeled when they were taken to the nursing unit refrigerators. On 6/16/05 at 9:35 AM, observation of the resident's refrigerator located in the activity room revealed the following concerns: a. The refrigerator had an unlabeled, undated pitcher of brown liquid. Interview with the activity staff member at the time of the observation revealed he thought it was iced tea. b. There were twelve batteries stored in the door of the freezer. The freezer contained three uncovered frozen bananas and an open box of ice cream bars for residents.	F 371	F371 – Dietary Services The correction of this tag has been accomplished by the following: The outdated food items have been removed from the refrigerators and all containers have been dated. The batteries have been removed from the freezer and all opened items have been discarded. All residents are at risk if food is unlabeled or improperly stored. An in-service on proper storage and labeling of food items will be provided by the training coordinator for employees of the dietary, nursing and activities departments. A "walkabout" checklist will be given to the department managers monthly and they will work in pairs to monitor the condition of food storage areas. Results will be reported to the dietary manager and nurse manager for appropriate action. These results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	6/16/05 8/5/05
F 445 SS=F	483.65(c) INFECTION CONTROL Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of infection control policies and procedures, and review of laundry procedures, the facility failed to ensure linen was handled in a manner that prevented the spread of infection. The findings were: During a tour of the laundry area on 6/16/05 at 10	F 445		

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WYOMING RETIREMENT CENTER	990 HWY 20 SOUTH BASIN, WY 82410

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F 445	Continued From page 23 AM the following concerns were identified: a. Interview with a laundry staff member revealed the same staff who sorted the dirty linen also handled the clean linen. The staff member further stated staff wore gloves but did not routinely wear gowns or any kind of clothing protection when sorting the dirty linen prior to handling the clean linen. b. Review of the facility's standard operating procedure for washing laundry dated 7/00 revealed instructions to "Put on long sleeved gown, gloves and mask/goggles." Review of the infection control policy on laundry/linen dated 12/03 revealed the following instructions: "Employees sorting or washing linens must wear a gown/apron, gloves, and if aerosolization occurs, a mask." c. Interview with the housekeeping manager on 6/16/05 at 12:27 PM confirmed laundry staff did not routinely wear gowns when sorting soiled linen.	F 445	F445 – Infection Control - Laundry The correction of this tag has been accomplished by the following: The laundry staff has been instructed by the laundry supervisor to use personal protective equipment as per policy when working with soiled laundry. All residents are at risk for nosocomial infection due to improper handling of soiled linens. The housekeeping supervisor has updated the laundry policy and procedure for handling of soiled linens to meet current infection control guidelines. An in-service on correct handling of soiled linens will be presented to all laundry personnel. The housekeeping supervisor will make the proper handling of soiled linens a focus issue to ensure that a change in practice does occur. The results will be reported at the quarterly Quality Assurance meeting and reviewed by the Medical Director.	6/20/05 6/20/05 8/5/05
F 468 SS=B	483.70(h)(3) PHYSICAL ENVIRONMENT The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all corridors had handrails in two of two nursing units. The findings were: 1. Observation of the north nursing unit on 6/16/05 at 8:30 AM revealed there were missing or partially missing handrails in the following resident areas: along the left wall (facing the outside) in the library area; approximately 20	F 468		

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F 468	Continued From page 24 inches missing outside rooms 204, 205, 209, 210, 213, 215, 230, 235, 239, 240, 243, and 245; approximately 30 inches outside rooms 203 and 233; approximately 47 inches by the water fountain; approximately 70 inches outside room 218; approximately 16 inches between room 230 and the smoking room; and there was no handrail along the wall between the nurses' desk and shower room. In the north special care unit, there were missing handrails for an area measuring approximately 20 inches outside resident rooms 219, 220, 223 and 224 and an area approximately 45 inches outside room 229. 2. Observation of the south nursing unit on 6/16/05 at 9:40 AM revealed there were missing or partially missing handrails in the following resident areas; approximately 20 inches outside rooms 305, 308, 309, 313, 320, 324, 325, and 328; approximately 30 inches outside room 333, approximately 42 inches outside the room by physical therapy, approximately 70 inches between room 318 and the south special care unit double doors. 3. On 6/16/05 at 3 PM, the administrator stated he was expecting a deficiency regarding handrails because there were gaps in them throughout the facility.	F 468	F468 - Physical Environment - Handrails After reviewing all information, appropriate handrails will be requested for installation in the facility. All residents are at risk for injury if handrails are not readily available throughout the building. The administrator has formed a team to address the handrail issue. The administrator will require and request assistance from Milt Warner and/or Dr. Paul Long on this issue. There are some questions as to when and where handrails are required in the facility and clarification of the definition of a hallway versus a common area is needed. These findings and any subsequent recommendations will be reported to the Quality Assurance Committee at their quarterly meeting and to the Medical Director.	8/5/05 8/5/05