JC 5/12/05

PRINTED: 04/15/2005
FORM APPROVED
OMB NO. 0938-0391

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
	535040	A. BUILDING _____ B. WING _____	04/07/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

(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 164 SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide privacy during cares for one of eleven sample residents (#43). The findings were: Review of the 3/2/05 quarterly Minimum Data Set (MDS) assessment showed resident #43 was severely cognitively impaired. Observation on 4/5/05 at 1:35 PM revealed certified nurse aides (CNAs) #11, #15, #19 provided perineal (incontinence) care for the resident. The door was closed, and the privacy curtains were partially	F 164	The facility will ensure personal privacy will be maintained for each resident. This will be accomplished by: CNAs will be in-serviced on the issue of privacy by insuring that privacy curtains are completely closed whenever cares are being given. If the privacy curtains are found not to be able to be closed because of insufficient width, housekeeping is to replace immediately with curtains of adequate size. including resident # 43 (jc) All staff will be educated on the issue of waiting for a response from either resident or staff before entering the resident's room. will be reviewed during quarterly QA meetings. (jc)	5/5/05

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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F 164	Continued From page 1 pulled. However, there was a gap of approximately three feet at the foot of the bed where the curtains did not meet. During the provision of care, a person employed in the laundry department (employee #A3) knocked on the door and entered the room without waiting for permission from the resident or staff. The employee walked past the curtain at the foot of the bed, then turned her head and observed the resident, who was completely exposed from the waist down. Interview on 4/5/05 at 2:00 PM with the laundry staff member revealed he/she usually knocked on doors, but did not wait for a response before entering.	F 164		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policies, the facility failed to assure a restraint was used to treat a medical symptom and was the least restrictive approach for one of five sample residents with restraints (#43). The findings were: Review of the 3/2/05 quarterly Minimum Data Set (MDS) assessment showed resident #43 utilized a trunk restraint daily. According to the March 2005 physician orders, a QRSB (quick release seat belt) was ordered for the resident while up. The care plan dated 3/15/05 instructed staff to	F 221	Each resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This will be accomplished by: All the non-releasing seat restraints will be replaced with quick release seat belts. Non-releasing seat restraints will not be used in the facility. This will be monitored by staff nurses, social services, and the restorative aide. Weekly chart reviews have been implemented to ensure that all residents who have previously had quick release seat belts on a prior admission are evaluated for new orders for quick release seat belts before using.	5/23/05

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F 221	Continued From page 2 utilize a QRSB for the resident. Review of the 11/29/04 Resident Assessment Protocol (RAP) module for restraints showed the resident used a QRSB while up in the wheelchair. The physical restraint consent form dated 12/10/04 documented the resident used the QRSB. Review of 3/03/05 social service notes showed the resident used the QRSB because he/she sometimes rose without assist. However, observation on 4/5/05 at 4:30 PM and on 4/5/05 from 7:45 AM until 1:35 PM revealed the resident utilized a non-releasing seat belt in the wheelchair. The following concerns were identified regarding the non-releasing belt: a. Medical record review revealed no physician order, no assessment, no care plan, and no consent form for the use of the non-releasing seat belt. Interviews with registered nurses (RNs) #1 and #2 on 4/6/05 at 8:57 AM and on 4/7/05 at 11:15 AM revealed the resident used to have a QRSB, but was now in a non-releasing belt. Neither knew how long ago the belt was switched. Both RNs confirmed the belt was a restraint for the resident. Review of the facility's policy "Physical Restraints" (NP1-111, 1/96) revealed the interdisciplinary team should follow a systematic evaluation and care planning process prior to using restraints. The policy also indicated written consent and a physician's order should be obtained before a restraint is applied. b. During interviews on 4/6/05 at 9:40 AM and on 4/7/05 at 10:04 AM, the social services director stated the resident used to have a QRSB, which the resident could release. She stated after the resident's re-admission from the hospital (in November 2004), the resident released the QRSB and had a fall. When asked about an assessment and care plan for the non-releasing belt, she stated "We must have missed it." Review of	F 221	F221 (Continued from previous page) All physical restraints will be released during meal times. Will be reviewed during Quarterly QA meetings. (HC).	

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F 221	Continued From page 3 nursing notes since the resident's re-admission on 11/19/04 failed to reveal documentation of a fall that occurred when the resident released the QRSB. c. Observation of the resident on 4/5/05 from 7:45 AM until 11:40 AM revealed the resident was in the wheelchair with the seat belt in place. The belt was not released during that time period. According to the facility's policy "Physical Restraints" (NP1-111, 1/96), the restraint should be released every two hours for ten minutes.	F 221		
F 225 SS=D	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	This facility will ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the administrator of the facility and to other officials in accordance with State law. The employee in question had a background check done before employment and the result, from all 50 states, was unblemished. On the day of the allegation of abuse, 3/18/05, the administrator reported the incident to Jean McLean of the WY Department of Health explaining that there was an accusation of abuse against our DON from supposedly 6 days earlier. When asked why the accuser waited so long to report it, she replied that she wanted to make sure that it actually had happened. The investigation began as soon as the incident was reported, the DON was notified the morning of 3/19 and was immediately put on suspension. She was not to return to work because of the allegation. Other departments that	4/8/05

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F 225	Continued From page 4 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 staff interview, review of internal investigations, and review of policies and procedures, the facility failed to report and investigate one of one allegations of abuse as required by federal regulations and State statute. In addition, the facility also failed to appropriately protect residents from potential abuse during the investigation. The findings were: Interview with the administrator on 4/4/05 at 2:55 PM revealed the facility recently investigated an allegation of abuse against the director of nursing (DON), but had not made a decision as to whether or not the allegation was substantiated. Review of the completed internal investigation showed the allegation was made on 3/18/05, and the DON was suspended on that date. However, the DON was in the facility on 4/4/05. Further interview with the administrator revealed the DON was in the facility all day but was not to have direct resident contact. In addition, the administrator stated the DON was to be monitored by the administrator or social services director (SSD) while she was in the facility. The following concerns were identified: a. During the aforementioned interview, the	F 225	F 225 (Continued from previous page) were notified were the omsbudsman & the department of licensure for the state board of nursing. We received a statement from the accuser and one from the only witness, a CNA. The CNA stated that the incident had never occurred, however the accuser was adamant of what she states she had seen. I found no other witnesses to the incident and all this information was sent to Jean McLean plus the statement we received from the accused denying the allegation. I also sent the same information to the board of nursing and to the Departmento of Family Services. On the day of the inspection I had asked the DON to come in and finish her QA minutes (which were not yet typed) with the stipulation that she have no contact with the residents. A copy of the letter which was sent to the DON was sent to Jean McLean as well. The DON completed the typing and went to her office to copy the minutes. It was at this time that the survey team arrived. Later, as I was sitting in the dining room she entered the dining room and began pouring water for the residents. I typed up a note and told her that she was terminated immediately because she did not abide by the guidelines previously set forth. ~~There still has been no determination of guilt or innocence of the alleged incident.~~ delete	

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F 225	Continued From page 5 administrator stated she was the person responsible for conducting the abuse investigation. She further stated she had completed the investigation but had not made a decision about the allegation. Therefore, she had not reported the results of the investigation to the State survey and certification agency within five days of the allegation. b. Observation showed the DON was alone at the nurses' station at 3:40 PM; large numbers of residents passed by the nurses' station at will. At 4 PM the DON was walking alone down the women's hallway past rooms where residents resided. At 4:25 PM the DON was alone in the nursing office for two minutes; residents were later seen wandering freely in and out of the nursing office. At 5:15 PM the DON was again walking down the women's hallway unaccompanied by staff. During the observations, the DON was not monitored by the administrator or SSD and had opportunity for resident contact. c. According to the internal investigation, the facility did not report the allegation to the police or to the Department of Family Services (DFS) as required by State statute. When questioned on 4/4/05 at 2:55 PM and on 4/7/05 at 7:28 AM, the administrator confirmed she had not reported the allegation to DFS or the police. Review of the facility's undated policies and procedures related to abuse revealed the following: - According to the policy, "Reporting abuse to state agencies/other entities/individuals", all allegations "will be promptly reported to the appropriate state agencies and others as required by law." - Information in the policy, Abuse Investigations, showed results of the investigation "will be provided to the Wyoming Department of	F 225	F 225 (Continued from previous page) This has been a learning experience for the administrator and she will never forget to notify DFS again in the investigation process. The administrator will follow the procedure as laid out step-by-step in the policy book. ~~There still has been no determination of guilt or innocence of the alleged incident.~~ delete Results of investigation will be faxed to State survey agency. Will review in quarterly QA meetings. (jel)	5/12/05

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F 225	Continued From page 6 Health Quality [State survey and certification agency] within five (5) business days." - According to the policy, "Protection of residents during abuse investigations," "...the residents will be protected from harm..."	F 225		
F 241 SS=D	483.15(a) QUALITY OF LIFE 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, medical record review, and staff interview, the facility failed to provide an environment that maintained dignity for one of eleven sample residents (#43) and one non-sample resident (#27). The findings were: 1. Review of the 1/3/06 quarterly Minimum Data Set (MDS) assessment showed resident #27 was severely cognitively impaired. Observation on 4/5/05 at 8:06 AM revealed the resident propelled himself/herself in the wheelchair away from the dining room table. The resident was just outside the dining room and was talking to certified nurse aide (CNA) #13 about how he/she didn't feel well. Staff member #A2 approached the CNA and resident, and stated the resident needed to drink more orange juice. Without talking to the resident, or asking the resident if he/she wanted more orange juice, the staff member grabbed the wheelchair, turned it around, and pushed the resident back to the dining room table. 2. Observation on 4/5/05 at 1:23 PM revealed	F 241	This facility will provide an environment that maintains dignity for the residents. This will be accomplished by: including res # 43 and #27 (jc) A) Staff will be re-educated on dignity and respect issues whether in the dining room or any other room in the facility. B) Staff members are to check with resident as to whether or not they are through with their meal before removing them from the table. C) Staff members are to report to the nurse in charge if they are informed of a resident not feeling well. D) All staff will be in-serviced on the issue of waiting for a response from either resident or staff before entering the resident's room. E) Administration will monitor staff as to compliance. will review in quarterly QA meetings. (jc)	5/5/05

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F 241	Continued From page 7 resident #43 was seated in the wheelchair in his/her room. Staff member #A2 walked into the resident's room without knocking first. Review of the 3/2/05 quarterly Minimum Data Set (MDS) assessment showed the resident was severely cognitively impaired. Observation on 4/5/05 at 1:45 PM revealed certified nurse aides (CNAs) #11, #15, and #19 were providing personal cares to the resident. A laundry staff member (employee #A3) knocked on the door, and then opened the door without waiting for a response from the resident or staff in the room. Interview on 4/5/06 at 2:00 PM with the staff member revealed he/she usually knocked on doors, but did not wait for a response before entering. During an interview on 4/7/05 at 4:50 PM, the administrator stated staff should knock on resident doors and wait for a response before entering.	F 241		
F 253 SS=D	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 staff and resident interviews, the facility failed to provide maintenance and housekeeping services to maintain a comfortable and sanitary interior in one of two shower rooms and the ice machine room. The findings were: 1. During a confidential interview on 4/6/05, two residents stated the shower room was not	F 253	This facility will provide maintenance and housekeeping services to maintain a comfortable and sanitary interior. This will be accomplished by: A) The cracked paint will be scraped from the ceiling and repainted. B) The grip strips on the floors will be replaced periodically when signs of deterioration appear. C) This will be monitored by maintenance and will be put on his weekly maintenance checks.	5/23/05

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F 253	Continued From page 8 "homelike". Observation on 4/4/05 at 4:26 PM and again on 4/5/05 at 6:30 PM of the women's shower room revealed the following concerns: a. The paint on the ceiling was cracked and peeling; b. The grey concrete floor was discolored with white spots; c. There were six holes visible on the wall and on the floor where a wall partition was removed; d. There was a blue streak on the wall from the hot water faucet to the floor; e. There was one bracket on the wall for a towel rack; the rest of the rack and the other bracket were missing. Interview on 4/7/05 at 7:40 AM with the maintenance director revealed he was not sure of any plans to remodel the shower room. During an interview on 4/7/05 at 8 AM, the administrator stated the shower room needed to be tiled, but they hadn't submitted any plans for remodeling yet. 2. Observation on 4/6/05 at 8 AM of the ice machine room revealed three tiles from the wall behind the door had come loose, and were on the floor. There was visible dirt along the edges of the floor, particularly behind the door. During an interview on 4/7/05 at 7:40 AM, the maintenance director stated he was not aware of the loose tiles.	F 253	F 253 (Continued from previous page) D) The holes in the wall will be filled. E) The blue streak on the wall is from the minerals in the water. The wall be repainted and sealed. F) The bracket has been replaced and will be monitored by maintenance on his weekly maintenance checks. G) Shower room will be re-tiled as soon as a contractor is available. H) All the tiles in the ice machine room will be replaced. I) The ice machine room will be added to the weekly schedule for the housekeeping department to maintain cleanliness. The maintenance director was not aware of many issues in the facility because he is a newly-hired employee and inexperienced as to nursing home maintenance obligations. He is being further trained as to what, why, and where and we feel he will be very competent in the future. will review in quarterly QA (dc)	
F 271 SS=D	483.20(a) RESIDENT ASSESSMENT At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.	F 271	F 271 On next page	

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F 271	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policies, the facility failed to obtain signed physician orders prior to admission for 1 of 12 sample residents (#16) admitted to the facility. The findings were: On 4/5/05 at 8:30 AM, review of the form, Physician Transfer Orders, showed it lacked signed and dated physician orders for resident #16 to be admitted to the facility. According to the face sheet the resident was admitted on 3/1/05. Interview with registered nurse (RN) #2 on 4/5/05 at 12:55 PM confirmed the lack of signed and dated admission orders. During the interview, the RN stated the facility had no other orders for the resident's admission. During an interview on 4/5/05 at 3:55 PM, the Minimum Data Set coordinator (also an RN) verified the facility did not have a signed admission order. Review of the facility's January 1996 policy, "Physician's Orders" (NP1-507) revealed "Physicians' orders must be signed by the physician and dated when such order was signed." During an interview on 4/14/05 at 1:30 PM, the Assistant Executive Director, Practice and Education Consultant, for the Wyoming State Board of Nursing, stated that without a physician's signature, and in the absence of a verbal order, "There is no order."	F 271	This facility will obtain signed physician orders prior to admission. This will be accomplished by: A) Nurses will be educated as to the importance of obtaining physician orders prior to admission. B) An addendum is in progress to the policy concerning admissions: a. No resident will be accepted for admission or re-admission from the hospital or other facility until written orders are obtained and signed by the attending physician. A signed copy of orders for res #16 was provided by the hospital and is included in the chart. Will be reviewed in quarterly QA meetings. (JE)	4/25/05 5/23/05
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT Within 14 days after the facility determines, or should have determined, that there has been a significant change in the residents physical or mental condition. (For purpose of this section, a	F 274	This facility will not fail to complete a significant change assessment for residents who require assessments, including res #3 This will be accomplished by:	

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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
	535040	A. BUILDING _____ B. WING _____	04/07/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

(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 274	Continued From page 10 significant change means a major decline or improvement in the residents 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 residents health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change assessment for one of four sample residents (#3) who required that assessment. The findings were: Review of nurses' notes dated 1/29/05 showed resident #3 was admitted to the hospital on that date for pneumonia and a urinary tract infection. Comparison of the 11/29/04 quarterly Minimum Data Set (MDS) assessment with the 2/8/05 assessment, which the facility coded as a Medicare 5-day assessment after the resident's return to the facility, showed the resident declined in the following areas: - bowel status - from incontinent of bowel weekly to incontinent all (or almost all) of the time (2 to 4). -personal hygiene - from requiring limited assistance of staff to total dependence on staff (2 to 4). - bed mobility and dressing - from requiring extensive assistance from staff to total dependence on staff (3 to 4). During interviews on 4/5/05 at 4:05 PM, the MDS coordinator and the social services director each stated there was "absolutely no change" in the	F 274	F 274 (Continued from previous page) A) By assuring that upon any significant change in condition an assessment will be done to indicate the change in condition. Our new MDS coordinator will be sent to MDS training to enhance her knowledge in proper documentation for MDS purposes. B) MDS Coordinator will review previous MDS and compare the numbers to be alert for a significant change and code as such. C) Weekly MDS meetings will be incorporated with our weekly Medicare meetings to discuss and evaluate residents needs. D) Our new MDS coordinator will double check the assessment for signatures. A monitoring tool will be put into effect in the form of a checklist. E) MDS coordinator has been re-instructed on the proper coding of MDS assessments. This will be added to the monitoring checklist tool used by the MDS coordinator. will be reviewed in quarterly QA. pe	5/23/05 5/23/05 5/23/05 5/23/05 5/23/05

5/12/05

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F 274	Continued From page 11 resident's condition upon return from the hospital. However, during an interview on 4/7/05 at 9:40 AM, the MDS coordinator agreed the facility should have completed a significant change assessment. According to the December 2002, Centers for Medicare & Medicaid Services Revised Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0, Guidelines for Determining Significant Change in Resident Status, Chapter 2, page 9, the changes described above warranted completion of a significant change assessment.	F 274		
F 278 SS=B	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than	F 278	This facility will ensure that resident assessments accurately reflect the resident's status. This will be accomplished by: A) The MDS coordinator will double check the assessment for signatures. A monitoring tool will be put into effect in the form of a checklist. B) The MDS coordinator has been re-instructed on the proper coding of MDS assessments. This will be added to the monitoring checklist tool used by the MDS coordinator. C) By assuring that upon any significant change in condition an assessment will be done to indicate the change in condition. Our new MDS coordinator will be sent to MDS training to enhance her knowledge in proper documentation for MDS purposes.	5/23/05 5/23/05 5/23/05

5/12/05

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MICHAEL MANOR	1106 BIRCH STREET DOUGLAS, WY 82633

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F 278	Continued From page 12 $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the accuracy and completeness of assessments for 8 of 11 sample residents (#1, #3, #10, #11, #16, #25, #29, #39). Sections VB1 and VB3 were not signed in various Resident Assessment Instrument (RAI) assessments for each of the identified residents. In addition, a quarterly Minimum Data Set (MDS) assessment was coded incorrectly for resident #3. The findings were: 1. Review of each resident's assessments revealed signatures were missing from Sections VB1 and VB3 for the following RAI assessments: a. The 11/17/04 admission assessment for resident #1; b. The 6/17/04 annual assessment for resident #3; c. The 9/10/04 annual assessment for resident #10; d. The 3/18/05 annual assessment for resident #11 e. The 3/4/05 admission assessment for resident #16; f. The 10/18/04 annual assessment for resident #25; g. The 2/9/05 annual assessment for resident #29; h. The 2/23/05 annual assessment for resident #39. Interview with the MDS coordinator on 4/6/05 at 4:10 PM confirmed signatures were lacking at Sections VB1 and 3. The coordinator stated she	F 278	F 278 (Continued from previous page) D) MDS Coordinator will review previous MDS and compare the numbers to be alert for a significant change and code as such. E) Weekly MDS meetings will be incorporated with our weekly Medicare meetings to discuss and evaluate residents needs. will be reviewed in quarterly QA. (JC)	5/23/05 5/23/05

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F 278	Continued From page 13 had never signed those sections as she was unaware they needed to be signed. According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Section VB1 is for the signature of the registered nurse coordinating the Resident Assessment Protocol process, and Section VB3 is for the signature of the staff person facilitating the care planning decision-making process. The signatures do not have to be the same, but both are required. 2. Review of the 2/8/05 MDS assessment for resident #3 showed it was only coded as a Medicare 5-day assessment, even though a quarterly MDS assessment was due. In addition, although the facility documented declines in the resident's status, Section Q2 was coded "No change." Refer to F 274 for information related to lack of a significant change assessment. Interview with the MDS coordinator on 4/5/05 at 4:05 PM revealed the 2/8/05 assessment should also have been coded as a quarterly assessment. During the interview, the coordinator stated she was unaware assessments could be coded in both categories.	F 278		
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, staff interview, medical record review, and review of policies and	F 281	This facility will ensure that services we provide or arrange meet professional standards of quality. This will be accomplished by: including res #1, #3, #10, #16, #22 (jc)	

5/1/2005

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F 281	Continued From page 14 procedures, the facility failed to assure professional standards of practice related to medication administration, physician orders, and assessments were followed for 5 of 11 sample residents (1, #3, #10, #16, #22). The findings were: 1. On 4/5/04 at 7:30 AM observation showed resident #3 lying on the floor under a table in the dining room. The resident was yelling and complained of pain "everywhere" but specifically in the right leg. Registered nurse (RN) #2 stated the resident fell with the legs behind him/her. The RN also stated she was unable to bend to assess the resident, but the resident complained of severe pain when she (the RN) tried to straighten the right leg. Staff obtained the resident's blood pressure, then without further assessment, rolled the resident onto a sling, pulled him/her out from under the table, lifted the resident up per mechanical lift, placed him/her in a wheelchair, and wheeled him/her to the nurses' station. According to a statement from RN #2 at 7:63 AM, the ambulance was called to transport the resident to the emergency room to rule out a fractured leg or hip. All staff present denied witnessing the incident. The following concerns were identified: a. Although the fall was unwitnessed, staff failed to complete a basic nursing assessment, or a primary or secondary trauma assessment. Observation revealed staff did not obtain a complete set of vital signs which included pulse and respiration until 7:53 AM, 23 minutes after the resident was found. An oxygen saturation level was never obtained. According to the sixth edition of "Clinical Nursing Skills" by Smith, Duell, and Martin, a basic nursing assessment includes vital signs as well	F 281	F 281 (Continued from previous page) 1. Education of staff nurses has included assessment procedure of residents post fall, including not moving a resident until they are immobilized. RN had attempted to bend the knees of the resident. The knees of this resident have bilateral knee hardware preventing assessment of range of motion. Vital signs post-incident now include BP, Pulse, Resp, Heart rate and O2 saturation levels. 2. Education of staff nurses for preparation of insulin administration include: gently tilting the bottle of insulin or gently rolling the bottle between the palms. Policy addendum includes instruction on use of syringe to avoid contamination of the plunger. One on one education and return demonstration from all nurses concerning policy is in place. Written documentation of successful education is on file. 3. Education of nurses and addendum to policy concerning admissions: No resident will be accepted for admission or re-admission from the hospital or other facility until written orders are obtained and signed by the attending physician.	4/25/05 4/21/05 4/21/05

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F 281	Continued From page 15 as musculoskeletal and neurological checks. According to the same reference, a primary trauma assessment (including neurological and disability evaluations) should be performed after any injury to identify the victim's primary and critical problem. A secondary, head-to-toe assessment (focused) should be completed next before any treatment is provided. The assessment includes assessment of the head, neck, shoulders, chest, arms, abdomen, pelvis, legs, and back. b. Although the resident complained of severe pain especially in the right leg, RN #2 stated she attempted to straighten the leg. In addition, the resident was moved without any attempt to immobilize the leg. According to the sixth edition of "Clinical Nursing Skills" by Smith, Duell, and Martin, "Never move an extremity yourself to see if it is fractured. Ask if the client is able to move the limb...splint the extremity as found...Never straighten an injured extremity..." 2. Observation on 4/5/05 at 4:40 PM showed RN #2 prepared insulin for administration to resident #10. The RN shook the vial of insulin, then drew air into a syringe and added it to the vial. With her fingers around the plunger of the syringe (which contaminated the syringe and any medication which would be in it), the RN withdrew insulin into the the syringe and worked the plunger back and forth to remove air bubbles. When that was unsuccessful, the RN kept her fingers around the plunger of the syringe and injected some of the insulin back into the vial, thus contaminating the remainder of the insulin in the vial. With her fingers still around the plunger, the RN withdrew the correct amount of insulin, checked for air bubbles, and replaced the vial in the refrigerator for future use. The RN administered the insulin to	F 281	F 281 (Continued from previous page) 4. Education of nurses includes locking the cabinets at nursing station and med cart, as well as gate to nurses station are to be locked at all times when left unattended. 5. Bedtime" is resident specific. This particular resident usually prefers bedtime immediately after supper. This has been recognized as a pharmacy error but nurses have been educated to review MARs for dosing-time errors. 6. Nurses have been educated and policy is in place for chart checks of physician orders weekly. This should minimize future errors of this type. will be reviewed at Quarterly QA. (RC)	4/14/05 4/21/05 4/15/05

5/11/05

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F 281	Continued From page 16 the resident on 4/5/05 at 4:43 PM. Review of the 3rd edition of "Nursing Interventions & Clinical Skills", by Elkin, Perry, and Potter, showed one should avoid touching the plunger of a syringe and tap the side of a syringe to remove air bubbles. According to the sixth edition of "Clinical Nursing Skills" by Smith, Duell, and Martin, excess air is ejected with the syringe in an upright position. Further review of Smith, Duell, and Martin revealed insulin vials should be gently rotated instead of shaken. 3. On 4/5/05 at 8:30 AM, review of the form, Physician Transfer Orders, showed resident #16 lacked signed and dated physician orders for admission to the facility. This form included orders for care, treatment, and medications. Review of the face sheet showed the resident was admitted on 3/1/05. Refer to F 271 for information related to lack of admission orders. Interview with RN #2 on 4/5/05 at 1.05 PM revealed the original orders were sent to the physician's office to be signed, but they never arrived at the facility. The RN confirmed the unsigned orders were not acceptable. During the interview, review of the medical record with the RN showed the facility had administered Temazepam, Lopressor, NitroBid, Detrol, and Synthyroid without an order since the resident's admission. On 4/5/05 at 2:20 PM, the administrator produced a copy of the admission orders which the physician had signed that day. However, the physician backdated the orders to 2/24/05, and the facility accepted them without questioning the date. Review of the facility's January 1996 policy, "Physician's Orders", NP1-507, revealed "Physicians' orders must be signed by the physician and dated when such order was signed." During an interview on 4/14/05	F 281		

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F 281	Continued From page 17 at 1:30 PM, the Assistant Executive Director, Practice and Education Consultant, for the Wyoming State Board of Nursing, stated that without a physician's signature, and in the absence of a verbal order, "There is no order." 4. Observation on 4/6/05 showed RN #4 left the medication cart unlocked three times while administering medications in the dining room between 5:09 PM and 5:20 PM. During this time period, numerous residents and staff members walked by the cart as they entered the dining room for the evening meal. While administering medications at 5:09 PM the RN had her back turned to the medication cart for one minute. At 5:12 PM the RN was turned away from the cart for 45 seconds. At 5:20 PM the cart was unlocked and the RN was just returning from the far end of the dining room. When asked at 5:20 PM if she normally left the cart unlocked, the RN replied, "No...I forgot." Review of the 3rd edition of "Nursing Interventions & Clinical Skills", by Elkin, Perry, and Potter, showed the medication cart must be kept locked when unattended. 5. Review of a physician order dated 1/28/05 showed resident #22 was ordered Paxil 10 milligrams (mg) at hs (bedtime). However, review of the February and March 2005 monthly recapitulation of physician orders showed an order for "Paxil 10 mg a.:" The frequency was not specified. The recapitulations were signed by the nurse and physician. Interview on 4/5/05 at 4:20 PM with registered nurse (RN) #3 revealed the "a:" showed up when the orders were put into the computer. The RN stated whenever an order was customized in the computer, it showed up like that. However, she stated that was not an appropriate order, and the nurses should have	F 281		

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F 281	Continued From page 18 clarified it. According to "Nursing Malpractice" by Hann Helm, copyright 2003, "...don't carry out any order from a physician if you have doubts about its accuracy or appropriateness. Follow your facility's policy for clarifying ambiguous orders." 6. Review of physician's orders revealed resident #1 received Prilosec without an order from 11/10/04 until December 2, 2004, a time period of 21 days. Interview with the administrator on 4/5/05 at 3 PM revealed the pharmacist received a verbal order for the medication and sent it to the facility. However, the facility did not receive the order, but staff administered the medication anyway. According to the July 2001 Wyoming Nursing Practice Act, nurses must practice under the direction of a physician.	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policies, the facility failed to provide repositioning assistance or encouragement for one of seven sample residents (#43) who required staff assistance for	F 309	This facility will assure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. This will be accomplished by: Re-educating CNAs and nurses regarding repositioning schedules and documentation of refusals will be mandatory. Residents will be cued every two hours and as needed. Residents in wheelchairs throughout the facility will be encouraged to reposition and/or lie down. Education also includes stabilization of catheter	including res #43 (JC) 5/10/05

5/1/05

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F 309	Continued From page 19 repositioning. The findings were: Review of the 3/2/05 quarterly Minimum Data Set (MDS) assessment showed resident #43 was dependent on staff for bed mobility and transfers. Review of the 11/29/04 Resident Assessment Protocol (RAP) module for pressure ulcers showed the resident had a history of pressure ulcers, and had an impaired ability to reposition himself/herself at regular intervals. Review of the 2/25/05 Braden Scale revealed the resident was at mild risk for pressure ulcers. The Braden scale indicated the resident had very limited mobility (makes occasional slight changes in body position but unable to make frequent or significant changes independently). Review of the care plan dated 3/15/05 showed staff should reposition the resident every two hours. Observation of the resident on 4/5/05 from 7:45 AM until 1:35 PM revealed the resident was seated in the wheelchair with a non-release seat belt in place. The resident was not observed to reposition himself/herself in the wheelchair. At 9:50 AM, certified nurse aide (CNA) #15 asked the resident if he/she wanted to lie down, but the resident shook his/her head no. The CNA did not encourage the resident to reposition in the wheelchair, nor did the CNA re-approach the resident again until 1:00 PM. At 1:00 PM, CNA #15 asked the resident if he/she wanted to lie down. The resident said no. The CNA did not encourage the resident to reposition in the wheelchair. At 1:35 PM, CNAs #15, #11, and #19 transferred the resident from the wheelchair into bed. The CNAs stated the resident had been in the wheelchair since breakfast. Observation of the resident's right buttock revealed the skin was bright red, with a crease from the catheter tubing visible on the buttock. During interviews on 4/6/05	F 309	F 309 (Continued from previous page) tubing over the top of the leg. An addendum to the policy includes repositioning and offering to toilet every two hrs and as needed. Oriented residents are encouraged to reposition every 15 minutes. will be reviewed at quarterly QA. (JE)	5/5/05

X 5/12/05

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F 309	Continued From page 20 at 8:57 AM and 4/7/05 at 10:25 AM, registered nurses (RNs) #1 and #2 stated if a resident didn't want to lie down, the CNAs should try to reposition the resident in the wheelchair. If the resident refused, the CNA should re-approach the resident again in a few minutes. The RNs stated the resident should not be left in the wheelchair for long periods of time without repositioning. During an interview on 4/7/05 at 10:27 AM, CNA #10 stated he/she was taught to at least stand the resident up from the wheelchair briefly to "get some weight off", if the resident did not want to get out of the wheelchair. Review of the facility's policy for pressure ulcers (2/8/02) revealed "...residents are repositioned in their chairs every hour and residents who are able are taught to move in their chairs every 15 minutes..." Review of the facility's policy "Physical Restraints" (NP1-111, 1/96) showed the restraint should be released every two hours and "...toilet and reposition the patient before reapplying the physical restraint."	F 309		
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff comments, medical record review, and review of policies and procedures, the facility failed to assure staff provided appropriate perineal (incontinence) care for one of eight residents (#29) who required it. The findings were:	F 312	This facility will ensure that a resident, including #29, who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This will be accomplished by: Re-education of CNAs and nurses to include appropriate perineal care after each incontinent period. This includes the groins, buttocks, thighs, as well as the labia, vaginal or penis area. This care will be provided regardless of the amount of urine or stool involved.	5/5/05

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535040	A. BUILDING _____ B. WING _____	04/07/2005

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MICHAEL MANOR	1109 BIRCH STREET DOUGLAS, WY 82633

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F 312	Continued From page 21 On 4/4/05 at 5:15 PM certified nurse aide (CNA) #19 provided perineal care to resident #29, who was incontinent of bowel and bladder. When questioned during the observation, the CNA stated the resident's brief was "moderately" wet. The CNA cleansed the resident's buttocks and anal area but did not cleanse the anterior thighs, groin, and vaginal area. According to the 2/9/05 annual Minimum Data Set assessment, the resident was completely incontinent of urine. Review of the facility's January 1996 policy and procedure, "Nursing Procedures Providing Perineal Care", showed perineal care "promotes cleanliness and prevents infection...removes irritating and odorous secretions that collect...on inner surface of the labia [skin folds in the vaginal area]." Further review of the policy and procedure showed perineal care for female residents included "...Separate labia with one hand and wash with the other...from front to back of perineum."	F 312	will be reviewed at quarterly QA. (JC)	
F 314 SS=D	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 314	This facility will ensure that a resident, including res #16 & #25, who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. This facility will also including res #16 & #25 ensure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This will be accomplished by: (JC)	

5/12/05

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F 314	Continued From page 22 Interviews, medical record review, and review of policies and procedures, the facility failed to assure 2 of 2 residents (#15, #25) with pressure sores, from a total sample of 11 residents, received necessary treatment and services to promote healing and prevent new pressure sores from developing. The findings were: 1. On 4/5/05 at 8:55 AM observation showed resident #25 had a dressing on the left hip; the dressing was dated 4/3/05 and had a dark area in the center which was approximately 1 inch in diameter. The certified nurse aides (CNA, #11 and #15) working with the resident at the time of the observation stated the dressing was for protection as the resident was "...very bony". At 9:15 AM on 4/5/05, RN #2 stated she was told of a wound on the resident's right hip which was very small, but she was unaware of the dressing on the left hip. On 4/6/05 at 9:45 AM RN #2 stated she was told in report there was a wound on the resident's left hip which was "like the [one on the] other side." The wound on the right hip was approximately 0.3 centimeters (cm) in diameter and was identified on 3/28/05. During the interview, RN #2 went to change the dressing but was very surprised at the size of the old dressing. Observation when the dressing was removed at 11:05 AM on 4/6/05 showed the RN was shocked at the size of the open wound. It measured 3.0 cm by 4.0 cm, with a beefy red base and no granulation tissue. The RN kept repeating, "It's not the same!" Interviews with the staff who worked on 4/3/05 revealed no one admitted putting the dressing on the resident's left hip. On 4/7/05 at 10:30 AM the administrator stated no one knew the condition of the resident's hip when the dressing was applied. In addition, the	F 314	F 314 (Continued from previous page) Education of nurses on admission skin assessment, documentation, and photograph if pressure ulcers are present will be presented. Education of nurses concerning wound care will also be taught. Wound rounds will be completed by the DON weekly. Education of CNAs and nurses on skin care will also be enacted. Education of CNAS and nurses will be taught on the appropriate methods of repositioning to avoid sheer, wrinkling of undersheets, and skin cleansing and drying. 1. Education of nurses concerning appropriate use and proper selection of dressings for wounds, including: a. Documentation of location, staging, and treatment of wound. b. Treatment and dressing will be performed according to standing orders. c. Physician will be notified of persistent non-healing wounds. d. Registered dietician will be consulted concerning supplements for skin care, i.e. Arginad bid for prophylactic and healing of wounds for at risk residents. Caloric and fortified supplements will continue as previous.	5/15/05 5/20/05

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

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F 314	Continued From page 23 administrator confirmed no one knew who applied the dressing. Furthermore, the physician was not notified and treatment orders were not obtained. Review of the physician's orders revealed the resident did not receive any nutritional or vitamin and mineral supplements. Interview with the dietary manager (DM) on 4/7/05 at 10:10 AM revealed she was not informed of either pressure sore. The DM verified the resident did not receive nutritional supplements. Review of the April medication administration record confirmed the resident did not receive vitamins or minerals. According to the facility's 2/8/02 policy and procedure related to skin integrity and pressure sores, the charge nurse or director of nursing (DON) "...will notify the dietary department to start a fortified food program, call and leave a message for the Registered Dietitian of new pressure ulcer and need for dietary assessment to be done...The DON and the wound nurse will stage the pressure ulcer and institute new pressure relieving devices/procedures...The charge nurse of each shift will assess the residents at risk or with a history of pressure ulcers daily and document condition of the skin...The wound treatment nurse will assess daily all pressure ulcers being treated and assess these residents for breakdown in other areas...and document." 2. Observation on 4/6/05 revealed resident #16 was not toileted or the brief checked or changed from 7:30 AM until 2 PM, a period of 6.5 hours. At 2:03 PM, the resident confirmed s/he had not been to the toilet since getting up that morning (some time before 7:30 AM). In addition, the resident stated no one had checked or changed the incontinence brief since s/he rose. At 2:05 PM two certified nurse aides (CNAs, #11 and #13)	F 314	-F 314 (Continued from previous page) 2. Education of CNAs and nurses will be taught regarding repositioning schedules and documentation of refusals. Residents are to be cued every two hours and as needed. Residents in wheelchairs throughout the facility will be encouraged to reposition and/or lie down. 5/10/05 a. Education of nurses on admission skin assessment, documentation, and photograph if pressure ulcers are present will be taught. 5/23/05 Education of nurses concerning wound care will also be taught. Wound rounds will be completed by the DON weekly. Education of CNAs and nurses on skin care will also be taught. Education of CNAS and nurses will be taught on the appropriate methods of repositioning to avoid sheer, wrinkling of undersheets, and skin cleansing and drying. 5/10/05 Program implemented for CNAs recording of changed skin conditions. Education of CNAS and nurses to reinforce policy of toileting prior to and following meals. 4/20/05	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 24 transferred the resident to bed. The resident required extensive assistance and the CNAs drug him/her over the bed. The resident was incontinent with a strong smell of urine. When questioned at the time of the observation, CNA #13 stated the resident's brief was "saturated" and the slacks were "damp." Observation during perineal care showed the resident had an open area on the left gluteal fold approximately 1.5 centimeters in diameter. CNA #11 applied A & D ointment to the area and stated it was not open yesterday. The following concerns were identified: a. Interview with charge nurse, registered nurse (RN) #2 on 4/6/05 at 9:50 AM revealed she was unaware of the open area before the CNA reported it to her on 4/5/05. b. Medical record review revealed no documentation related to the pressure sore before 4/5/05. The nursing note on 4/5/05 at 2:30 PM documented "A & D ointment used to cover" the open area. However, interview with the administrator on 4/7/05 at 5:20 PM revealed the facility used whatever treatment "...was learned at the last wound clinic". The administrator stated that treatment was Calmoseptine with a Tegaderm dressing applied after the area was cleansed with normal saline. The administrator further stated A & D ointment was not to be used. In addition, review of the physician's orders showed there was not an order for A & D ointment. c. Review of the facility's 2/8/02 policy and procedure related to skin integrity and pressure sores revealed, "Residents that are a two person transfer will be transferred without dragging...Skin will be kept clean and dry."	F 314	F 314 (Continued from previous page) b. No A&D ointment applied to open areas per policy. For Stage 1 Bag Balm will be applied, for Stage 2 Calmoseptine or Bacitracin will be applied. Non-occlusive dressings will not be used on open areas except skin tears. c. Education of CNAs and nurses on skin care. Education of CNAs and nurses on appropriate methods of repositioning to avoid sheer, wrinkling of undersheets, and skin cleansing and drying. will be reviewed during Quarterly QA. GE	4/28/05 5/10/05
F 316 SS=D	483.25(d)(2) QUALITY OF CARE	F 316		

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F 316	Continued From page 25 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, resident and staff interviews, medical record review, and review of policies and procedures, the facility failed to assure staff provided care and services to prevent urinary tract infections, promote dryness, and restore bladder function. One of eight (#16) sample residents who was incontinent of bladder was not toileted or changed. In addition staff failed to handle catheters appropriately during care for one of one sample residents (#43) with a catheter and for one non-sample resident (#32). The findings were: 1. Observation on 4/5/05 at 12:47 PM showed certified nurse aide (CNA) #11 pushed resident #16 to the room and asked if the resident wanted to use the toilet. When the resident refused, the CNA did not encourage or educate the resident, nor did the CNA check the resident's incontinence brief. The CNA just turned and left the room. Interview with the CNA on 4/5/05 at 12:50 PM revealed the resident usually refused to use the toilet from arising until approximately 1:30 PM so staff "...don't ask..." anymore. On 4/6/05 at 4:30 PM, interview with the charge nurse, registered nurse (RN) #2, revealed she expected staff to keep asking a resident if s/he needed to use the toilet if the resident had refused toileting. Observation on 4/5/05 revealed the resident was not toileted or encouraged to use the toilet, nor was the incontinence brief checked or changed, from 7:30 AM until 2 PM, a period of 6.5	F 316	This facility will ensure that a resident, including res #16, #43, #32 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 will be accomplished by: 1. Education of CNAs and nurses to reinforce policy of toileting prior to and following meals. An addendum to the policy includes repositioning and offering to toilet every two hours or as needed. Oriented residents are encouraged to reposition every 15 minutes. 2. Education of CNAs and nurses regarding the potential of back flow when catheter bag is above patient's bladder level per policy in NP2-1101. 3. Education regarding same policy concerning cleansing away from perineal area when cleaning catheter tubing. will be reviewed during quarterly QA. (jc)	5/5/05 5/21/05 and 5/6/05 5/5/05 (jc)

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F 316	Continued From page 26 hours. At 2:03 PM, the resident confirmed s/he had not been to the toilet since getting up that morning (some time before 7:30 AM). The resident also stated no one had checked or changed the incontinence brief since s/he rose. Review of the 3/4/05 admission Minimum Data Set assessment revealed the resident was not cognitively impaired but was frequently incontinent of urine. Review of the April 2005 activities of daily living flow sheet confirmed the resident was incontinent of urine every day. According to the 3/7/05 care plan, staff were to encourage the resident to urinate every two to three hours. When two certified nurse aides (CNAs, #11 and #13) transferred the resident to bed at 2:05 PM, s/he was incontinent with a strong smell of urine. When questioned, CNA #13 stated the resident's brief was "saturated" and the slacks were "damp." 2. Interview with RN #2 on 4/5/05 at 9:54 AM revealed resident #43 had a history of urinary tract infections and was on Pyridium for prophylaxis. According to Mosby's 2003 Nursing Drug Reference, Pyridium exerts an anesthetic effect on the urinary tract mucosa and is used for irritation caused by infections; it turns urine a red-orange color. On 4/5/05 at 1:35 PM observation showed three CNAs assisted the resident to bed. CNA #19 removed the residents trousers and pulled the indwelling catheter drainage bag through the trouser leg. However, the CNA elevated the catheter bag approximately 18 inches above the resident's bladder, and red-orange urine ran back up the tubing and into the resident. Review of the 3/2/05 quarterly MDS assessment showed the resident had a urinary tract infection, and, according to the March 2005	F 316		

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F 316	Continued From page 27 physician's orders, received Macrobid (an antibiotic) and Pyridium for it. Review of the facility's January 1996 policy and procedure, "Nursing Procedures Insertion of Indwelling Catheter", NP2-1101, showed "Keep drainage tube and collection bag lower then [than] bladder at all times." 3. Observation on 4/4/05 at 3:50 PM revealed CNA #2 provided catheter care for resident #32 by cleansing the catheter tubing with soap and water while using a back and forth motion. On 4/7/05 at 11:50 AM interview with CNA #13 revealed they were taught to cleanse catheters by rubbing away from the resident's body. Interview with RN #1 on 4/7/05 at 11:52 AM confirmed catheters were not cleansed with a back and forth motion; staff were to cleanse the tubing by rubbing away from the resident's body.	F 316		
F 318 SS=E	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, review of facility policies, and family and staff interviews, the facility failed to provide range of motion services for five of six sample residents with limited range of motion (#10, #11, #22, #39, #43). The findings were:	F 318	This facility will ensure that a resident, including #10, #11, #22, #39, #43 with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range in motion. This will be accomplished by: Reviewed procedure of documentation with restorative aide. Documentation will be completed for services. 4/25/05 1. Restorative aide recently returned to duty after absence due to injury and is providing range of motion per recommendations.	(c)

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F 318	Continued From page 28 1. Review of the 3/18/05 annual Minimum Data Set (MDS) assessment showed resident #11 had range of motion (ROM) limitations in the following areas: one arm, one hand, one leg, and one foot. Review of the 3/18/05 Resident Assessment Protocol (RAP) module for activities of daily living revealed the resident had right sided paralysis. Review of a 3/14/05 nursing summary showed the resident had contractures to the right arm, leg, and foot. Observation on 4/7/05 at 8:55 AM revealed the resident had decreased voluntary movement to the right arm and leg. Interview with certified nurse aide (CNA) #12 at that time revealed the resident had decreased range of motion to the right arm and leg. During an interview on 4/6/05 at 9:00 PM, a family member stated the resident was paralyzed on the right side of the body. Review of the medical record revealed no evidence the resident received ROM services. The care plan dated 3/31/05 did not address the resident's ROM limitations. Review of the restorative documentation book provided by the facility revealed the resident was not receiving restorative services. During an interview on 4/7/05 at 11:06 AM, the administrator stated if there was no documentation in the restorative book, then the resident was not receiving restorative services. 2. Review of the 2/23/05 annual MDS assessment showed resident #39 had ROM limitations in the following areas: neck, both arms, both legs, and both feet. Review of the 2/23/05 RAP module for activities of daily living revealed, that due to progressive Alzheimer's dementia, ROM was limited. Review of a 3/20/05 nursing summary showed the resident had contractures in the knees. Observation on 4/7/05 at 8:46 AM showed the resident did not straighten his/her	F 318	F 318 (Continued from previous page) 2. Restorative aide recently returned to duty after absence due to injury and is providing range of motion per recommendations. 3. Restorative aide recently returned to duty after absence due to injury and is providing range of motion per recommendations. Additional CNAs are being hired by facility. 4. Restorative aide recently returned to duty after absence due to injury and is providing range of motion per recommendations. Additional CNAs are being hired by facility. 5. Care plans updated and range of motion administered per restorative aide according to recommendations. 6. Restorative aide recently returned to duty after absence due to injury and is providing range of motion per recommendations. Additional CNAs are being hired by facility. 7. Restorative aide recently returned to duty after absence due to injury and is providing range of motion per recommendations. Additional CNAs are being hired by facility. Will be reviewed during Quarterly QA. (RC)	

X 8/1/26.

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F 318	Continued From page 29 knees while transferring. Interview with CNAs #15 and #16 at that time revealed the resident had "stiff" knees. Review of the medical record revealed no evidence the resident received ROM services. Review of the care plan dated 3/14/05 showed the ROM limitations were not addressed. Review of the restorative documentation book provided by the facility revealed the resident was not receiving restorative services. During an interview on 4/7/05 at 11:05 AM, the administrator stated if there was no documentation in the restorative book, then the resident was not receiving restorative services. The administrator stated the resident used to receive restorative services, and probably still should be. 3. Review of the 3/2/05 quarterly MDS assessment revealed resident #43 had ROM limitations in the following areas: neck, both hands, both legs, and both feet. Review of a 11/19/04 hospital discharge summary showed the resident had flexion contractures. Review of the 11/19/04 admission nursing note showed the resident was stiff in the joints that were contracted. Review of the restorative nursing plan dated 9/7/04 revealed the resident was supposed to receive ROM to the upper extremities. Review of the January 2005 restorative flow sheet showed the resident received ROM services five times. Review of the February and March 2005 restorative flow sheets revealed they were blank; there were no documented ROM services provided. Review of the April 2005 flow sheet (up through 4/7/05) revealed it was also blank. During an interview on 4/7/05 at 11:05 AM, the administrator stated the previous restorative aide did not document services provided. She further stated the current restorative aide was being pulled off of restorative to "work the floor" (as a	F 318		

5/12/05

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MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

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F 318	Continued From page 30 certified nurse aide). 4. Review of the 3/25/05 quarterly MDS assessment showed resident #22 had ROM limitations in the following areas: both legs, both feet, and other limitations. Review of a 1/6/05 physical therapy clarification order showed the resident was discharged to restorative. Review of the 1/14/05 restorative referral showed the resident was supposed to receive lower extremity exercises and ambulation one to two times per week. Review of a 3/23/05 physician progress note showed the resident had pain in the knees, and the facility was supposed to do a re-trial of restorative care. Review of the care plan dated 1/6/05 showed the resident received the restorative program as tolerated. However, review of the February, March, and April (through 4/7/05) 2005 restorative flow sheets showed they were blank. During an interview on 4/7/05 at 11:05 AM, the administrator stated the previous restorative aide did not document services provided. She further stated the current restorative aide was being pulled off of restorative to "work the floor" (as a certified nurse aide). 5. Review of the 3/4/05 quarterly MDS assessment showed resident #10 had ROM limitations in both legs and feet. Review of the 9/9/04 RAP module for activities of daily living showed the resident had one or more limbs that was severely impaired. The 3/1/05 nursing summary indicated the resident had a contractures to the leg and foot. Review of the medical record revealed no evidence the resident received ROM services. The care plan dated 3/17/05 did not address the resident's ROM limitations. Review of the restorative documentation book provided by the facility	F 318		

5/1/2005

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FORM APPROVED
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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
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F 318	Continued From page 31 revealed the resident was not receiving restorative services. During an interview on 4/7/05 at 11:05 AM, the administrator stated if there was no documentation in the restorative book, then the resident was not receiving restorative services. 6. During an interview on 4/7/05 at 11:05 AM, the administrator stated the previous restorative aide did not document services provided. She further stated the current restorative aide was being pulled off of restorative to "work the floor" (as a certified nurse aide). Review of restorative flow sheets in the restorative book showed the restorative aide documented he/she was pulled to work as a certified nurse aide on 2/28/05, 3/2/05, 3/3/05, 3/4/05, 3/7/05, 3/8/05, 3/9/05, 3/21/05, 3/23/05, and 3/24/05. 7. Review of the facility's policy for ROM exercises (NP2-1502, 1/96) showed ROM exercises improve or maintain joint mobility and help to prevent contractures. The policy stated the joints exercised and the number of repetitions should be documented on the restorative nursing flow sheets.	F 318		
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 store nursing supplies out of reach	F 323	This facility will ensure that the resident environment remains as free of accident hazards as is possible. This will be accomplished by: 1. Kick guards have been temporarily repaired and new kick guards are being ordered. 2. Baseboard heater across from room #4 has been reattached.	5/23/05

4/11/05

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

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F 323	Continued From page 32 of residents, to assure the doors and heaters were free of sharp edges, and that a steep stairwell and dumbwaiter were not accessible to residents. The findings were: 1. Observation on 4/5/05 at 1 PM and again on 4/7/05 at 7:40 AM revealed the hard plastic kick guards attached to the doors of resident rooms #4 and #6 were cracked, and bent up along the ends, which created sharp edges. During an interview on 4/7/05 at 7:40 AM, the maintenance director stated the kick guards were rough from beds and other things running into them. He further stated he was not aware of the sharp edges until the surveyor showed them to him. 2. Observation on 4/4/05 at 4:40 PM and again on 4/7/05 at 7:40 AM revealed the right side of the baseboard heater across from room #4 was not firmly affixed, which created a sharp edge. Interview on 4/7/05 at 7:40 AM with the maintenance director confirmed the sharp edge. He stated a screw could be inserted to re-attach the side piece. 3. Observation on 4/7/05 at 4:35 PM revealed a clean utility room which had an unlocked door. In one of the unlocked cabinets, there was a bottle of Betadine solution. In addition, the room contained a dumbwaiter (elevator) to transport clean linen from the basement to the main floor. The door to the dumbwaiter was not locked. The opening to the dumbwaiter measured 23 inches by 33 inches. Upon looking inside, the elevator was in the down position (at the basement), therefore there was a drop off down to the basement. 4. Observation on 4/7/05 at 4:38 PM revealed a	F 323	F 323 (Continued from previous page) 3. Betadine has been removed, door is locked at all times. 4/19/05 4. The key has been relocated to an inconspicuous place accessible to employees and door is kept locked at all times. 4/21/05 5. The gate and cabinets at the nurses station are to be kept locked at all times when nurse is not in attendance. The refrigerator containing the insulin is to be kept locked at all times when nurse is not in attendance. 4/19/05 will be reviewed at quarterly QA meetings. (JC)	

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

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F 323	Continued From page 33 door next to the nursing station. The door was locked, but there was a key visible hanging next to the door from a hook attached to the door frame. Behind the door was the steep stairwell to the basement; it contained 13 steps. 5. Observation on all days of the survey showed the cabinets at the nurses' station were not locked and contained such items as syringes, needles, and alcohol and Betadine wipes. In addition, insulin was kept in the refrigerator, and the 1/2 door at the nurses' station was not always locked so the area behind the door was accessible to residents.	F 323		
F 324 SS=D	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and medical record review, the facility failed to assure the safety of an assistive device which was used for 1 of 10 sample residents (#3). The findings were: On 4/5/05 at 7:30 AM observation showed resident #3 lying on the floor under a table in the dining room. When someone asked what happened, certified nurse aide (CNA) #11 stated "The wheelchair broke." CNA #15 examined the wheelchair but was unable to determine how it was broken. After the resident was removed from the floor, staff placed him/her back into the wheelchair. The resident was transferred to the	F 324	This facility will ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: the wlc for res #3 has been fixed. 4/28/05 (H) Wheelchairs are to be checked weekly when cleaned and as needed, and repaired as necessary. A work order will be initiated by the staff member who cleaned and checked the chair. Policy has been implemented for inspection of wheelchairs as resident is admitted to facility and repaired or replaced as necessary. Documentation of inspection to include date, resident name, safety concern and rectification of same. Any staff member taking note of any repair issue of wheelchairs will fill out a work order for immediate repair. 5/23/05	

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

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F 324	Continued From page 34 emergency room and later returned to the facility. During an interview at 8:30 AM on 4/5/05, CNA #11 stated she did not witness the incident, but the back of the wheelchair cushion was tipped up when she arrived at the scene. Interview with the charge nurse, registered nurse (RN) #2, at 9:06 AM revealed the resident was on his/her knees in front of the wheelchair and was held in place by the seat belt. The RN stated the seat belt was loosely fastened so the resident could rock forward to propel the wheelchair. The RN also identified the wheelchair as belonging to the resident. Review of the 6/10/04 annual and 2/8/05 quarterly Minimum Data Set assessments revealed the resident was not cognitively impaired, was at risk for falls, and used a wheelchair with a quick release seat belt. Review of the medical record produced no documentation related to a safety check for the wheelchair. During an interview on 4/5/05 at 10:17 PM, the maintenance director stated he had never checked the wheelchair for safety and did not know if anyone checked it when it was brought to the facility. Interview with the administrator on 4/6/05 at 3:10 PM confirmed the wheelchair was brought in by the resident's family approximately five months ago. The administrator was unable to provide documentation the wheelchair was checked for safety. At 11:20 AM on 4/5/05 observation showed CNAs #11 and #15 prepared to transfer the resident from the bed back into the wheelchair. At this time the CNAs discovered the back of the wheelchair seat would tip up and the whole bottom of the wheelchair would come out. They were unable to find a mechanism to lock the seat into place, but placed the resident in the wheelchair anyway. Both CNAs stated they were	F 324	Will be reviewed at quarterly QA. (JC)	

4/28/05

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

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F 324	Continued From page 35 unaware the seat would come out. On 4/5/05 at 2:22 PM the social services director also stated she was unaware the seat would tip up and come out.	F 324		
F 327 SS=D	483.25(l) QUALITY OF CARE The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews, and medical record review, the facility failed to assure staff provided 1 of 11 sample residents (#3) at risk for dehydration with adequate fluids to maintain health. The findings were: Review of the face sheet revealed resident #3 was admitted to the facility with diagnoses which included blindness and macular degeneration. Interview with a family member on 4/5/05 at 1:20 PM revealed the resident had ongoing urinary tract infections (UTIs) from November 2004 through a hospitalization in January 2005. The family member stated the hospital identified the resident as dehydrated on admission and started intravenous fluids and antibiotics. The family member also stated the resident was unable to see to obtain fluids, and when staff entered the room, they might or might not offer fluids to the resident. According to laboratory reports, the resident had UTIs on 11/22/04, 12/10/04, 12/28/04, 1/4/05, and 1/29/05. Review of nursing notes dated 1/29/05 showed the resident was hospitalized for a UTI and pneumonia. According to the 2/8/05	F 327	This facility will provide each resident, including res #3 (jc) with sufficient fluid intake to maintain proper hydration and health. This will be accomplished by: a. The facility has implemented a nutrition and hydration program with staff hired specifically to provide juice, water, popsicles, and fortified supplements to residents. CNAs are notified of residents needing help with hydration and supplements. Juice being provided includes cranberry juice as prophylactic for UTIs. (The resident referenced in F327 has a history of chronic UTIs.) A new policy was implemented covering hydration twice a day and at bedtime. All staff providing direct care for residents are being educated on hydration and nutrition. 4/18/05 b. Care plans are made accessible to the CNAs and part of their job function is to review the care plans daily and as needed. 4/28/05 c. Dietary assists with the hydration cart with stocking the cart with liquids and snacks. 4/18/05 d. All residents are monitored and encouraged to consume food and fluids at each meal by all staff present. 4/18/05	

4/12/05

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F 327	Continued From page 36 Minimum Data Set (MDS) assessment, the resident's vision was highly impaired and the facility documented s/he was dehydrated and had a UTI in the last 30 days. Review of the nursing notes and physician's orders dated 2/12/05 revealed the resident was started on Macrobid (an antibiotic for UTIs) for a month. According to the 2/17/05 care plan, staff were to offer fluids of choice at meals, offer fluids before and after cares, and keep water at the bedside. Review of the 7/1/04 initial nutrition assessment revealed the resident required 1,341 cubic centimeters (cc) of fluids per day. In addition, observation on all days of the survey showed signs posted by thermostats which instructed staff to keep the temperature set at or above 78 degrees; the facility was warm, but interview with the social services director on 4/7/05 at 10 AM revealed the hydration cart was not in use. The following concerns were identified: a. Observation on 4/4/05 5:15 PM, 4/5/05 at 11:20 AM, and 4/5/05 at 1:05 PM showed staff failed to offer fluids before or after completion of care; a total of six opportunities for fluids consumption were missed. b. Interview with two certified nurse aides (CNAs, #13 and #15) and the housekeeper who was also a CNA revealed all were unaware of the amount of fluid the resident needed to consume each day. In addition, CNA #13 stated he had been employed at the facility about nine months, but he was unaware of the instructions on the resident's care plan. c. Review of the documented fluid intake consumed by the resident at meals since his/her return from the hospital on 2/1/05 showed an average fluid intake in February of 560 cc per day and in March of 599.7 cc per day. Interview with the dietary manager on 4/6/05 at 3:20 PM	F 327	will be reviewed at quarterly QA. (fe)	

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F 327	Continued From page 37 revealed the dietary department provided fluids at meals, but it was the responsibility of the nursing staff to offer, or encourage consumption of, fluids. d. Observation during the evening meal on 4/4/05 at 5:45 PM showed the resident's tray pushed back on the table. An unidentified CNA stated the resident pushed the tray away at the evening meal; however, the CNA made no attempt to offer other fluids or encourage the resident to consume more fluids. Observation of the noon meal on 4/5/05 at 12:40 PM showed the resident sitting with his/her head on the table and the meal tray pushed away. Again, staff failed to offer other fluids or encourage the resident to drink those already provided.	F 327		
F 329 SS=D	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure one of one sample residents (#16) who received a hypnotic medication (psychotropic medication used for sleep) did not receive it unnecessarily. The findings were: Review of the admission face sheet showed	F 329	This facility will make sure that any resident who receives a hypnotic medication (psychotropic medication used for sleep) will not receive it unnecessarily. This will be accomplished by: The care plan is implemented for alterations in sleep patterns. Our pharmacy and social services personnel are in the process of developing support documentation for each resident prescribed with hypnotics. Pharmacy reviews monthly. The physician has addressed the hypnotic for res # 16.	5/23/05

5/12/05

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F 329	Continued From page 38 resident #16 was admitted to the facility on 3/1/05. Review of the admission orders showed the physician ordered Temazepam (a hypnotic) nightly, and, according to the March and April 2005 medication administration records, the resident received it as ordered. According to the 2005 PDR Nurse's Drug Handbook,Temazepam is for short term use only as "Prolonged administration is not recommended because physical dependence and tolerance may develop." Review of the entire medical record failed to show physician documentation explaining why the hypnotic medication was prescribed for more than short term use and why alternative methods of sleep induction, a decreased dose, or different medications were not attempted. In addition, the facility failed to provide evidence that other possible reasons for insomnia (e.g., new admission, depression, pain, noise, light, caffeine,) were eliminated. Interview with the social services director on 4/7/05 at 10:30 AM confirmed the facility lacked a physician's statement which supported continued use of the medication or documented that the benefits of daily consecutive use outweighed the risks.	F 329	Will be reviewed at quarterly QA meetings. (de)	
F 332 SS=E	483.25(m)(1) QUALITY OF CARE 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, resident and staff interviews, and review of policids, the facility failed to maintain a medication error rate below five percent (%). Observation revealed 5 non-significant medication errors out	F 332	This facility will ensure that it is free of medication error rates of five percent or greater. This will be accomplished by: A Nurse education lesson plan is being implemented concerning avoiding medication errors. 5/29/05 A) Nurses will be educated as to the importance of obtaining physician orders prior to admission. 4/20/05	

4/21/05

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 332	Continued From page 39 of 46 opportunities for error which resulted in an error rate of 11.11%. The findings were: 1. Observation on 4/4/05 at 5:43 PM showed registered nurse (RN) #2 administered Metoprolol, Detrol, and Prevacid to sample resident #16. Reconciliation of the medications revealed the lack of physician orders for Metoprolol and Detrol since the transfer and admission form was not signed or dated by the physician; nor were there any verbal or telephone orders for the medications. Refer to F 271 for information related to lack of admission orders. Interview and review of the medical record with RN #2 on 4/5/05 at 12:55 PM confirmed the lack of signed orders and the absence of any other orders for the medications. Two errors were made with administration of these medications. 2. Observation on 4/5/05 at 5:45 PM showed licensed practical nurse (LPN) #3 administered Calcium 600 milligrams (mg) with Vitamin D 200 mg to non-sample resident #42. Reconciliation of the medication revealed the physician's 3/3/05 order was for Calcium 600 mg with Vitamin D 600 mg. Further review of the physician's orders with RN #1 showed an order on 11/5/04 to change the Calcium to 600 mg with Vitamin D and administer it twice daily, but the amount of Vitamin D was not specified. However, the recapitulation (recap) of orders form signed by the physician on November 4, 2004, and each monthly recap of orders since then, specified Calcium 600 mg with Vit D 600 mg. When interviewed on 4/7/04 at 8:55 AM, RN #1 stated, "I don't have an answer." One medication error occurred. 3. On 4/5/05 at 5:12 PM, observation showed RN #4 administered medications, including Tagamet	F 332	F 332 (Continued from previous pages) B) An addendum will be made to the policy concerning admissions: a. No resident will be accepted for admission or re-admission from the hospital or other facility until written orders are obtained and signed by the attending physician. 4/20/05 1. Weekly chart checks will be completed for all residents. 4/28/05 2. We have gone to standard physician orders for Vitamin D (200 I.u.) and calcium (600 mg) (i.e. any order reading calcium 600 mg with Vitamin D is interpreted as Vitamin D 200 I.u.) 4/25/05 3. Nursing Policy # NP1-401 states "Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered....Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility." 4/8/05 will be reviewed at Quarterly QA meetings. (PE)	

4/11/05

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F 332	Continued From page 40 and Zyprexa, to non-sample resident #31. Reconciliation of these medications revealed both were ordered at bedtime on the March 2005 recap of orders. Review of the medication administration record showed both medications were routinely scheduled for administration at 6 PM. Interview with RN #1 on 4/7/05 at 9:05 AM revealed she had no idea why bedtime medications were given so early. Interview with the resident on 4/7/05 at 4:45 PM revealed s/he normally went to bed "about 8 PM." Two medication errors occurred.	F 332		
F 406 SS=D	483.45(a)(1)&(2) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with s483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provided ordered rehabilitative (rehab) therapy services for one of one sample residents (#16) with orders for therapy. The findings were: According to the face sheet, resident #16 was admitted to the facility on 3/1/05. Review of the admission orders showed the resident was to	F 406	This facility will ensure that rehabilitative services will be provided as ordered for any resident who has such orders. This will be accomplished by: (res #16) When this resident was admitted PT and OT were called and it was decided that the prosthesis could not be used until after the decubitis which was present on her amputation was healed. The PTA stated he would start rehabilitation with the resident using the prosthesis when the wounds were healed. Res #16 is receiving P.T. This facility is unaware of any conversation with PT or OT stating that therapies were not allowed to evaluate the resident. Hereafter, all conversations with therapies will be put in writing and kept in the resident's chart.	4/28/05

5/12/05

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	535040	A. BUILDING _____ B. WING _____	04/07/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL MANOR	1108 BIRCH STREET DOUGLAS, WY 82633

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F 406	Continued From page 41 receive therapy for wound therapy, wheelchair transfers, and strengthening exercises. However, review of the 3/10/05 occupational therapy (OT) note revealed the following: "When pt [patient] left hospital OT and PT [physical therapy] were under the understanding that [resident's name] would receive OT and PT services...The nurse on duty offered to call and get orders 2 [secondary] to director of nursing stating that they have to eat the cost of our services, since it was not ordered. She stated that it was not the wish of Michael Manor to get orders, because the restorative aide could complete transfer training and strengthening. Therefore OT will not be treating the pt at this time." Review of the entire medical record failed to show the facility obtained an order to discontinue rehab therapy or for the resident to receive restorative therapy. During an interview on 4/7/05 at 9:40 AM, the administrator stated PT decided not to do any therapy until the resident's pressure ulcer healed. She further stated rehab decided not to do any therapy at all. Interview with a physical therapy aide (PTA) on 4/7/05 at 9:58 AM revealed the physical therapist went to the facility to evaluate the resident and was told the resident was on restorative therapy. The PTA stated the therapist called the physician who reordered rehab therapy; the therapist returned to the facility but was not allowed to evaluate the resident. The PTA further stated the facility told OT "...the same thing."	F 406	Will be reviewed at quarterly QA - ye)	
F 429 SS=D	483.60(c)(2) PHARMACY SERVICES The pharmacist must report any irregularities to the attending physician and the director of nursing.	F 429	This facility will ensure the pharmacy will report any irregularities concerning the residents medications to the attending physician and the director of nursing. This will be accomplished by:	

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F 429	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, interview with the consultant pharmacist, and review of policies, the facility failed to assure the pharmacist reported irregularities for 1 of 11 sample residents (#16). The findings were: Review of the admission face sheet showed resident #16 was admitted to the facility on 3/1/05. Review of the admission orders showed they were neither verbal nor telephone orders; nor were they written, signed, or dated by the physician. During an interview on 4/5/05 at 1:05 PM, registered nurse (RN) #2 confirmed the orders were not acceptable since they were not signed. Review of the medical record during the interview with the RN revealed the facility had administered Temazepam, Lopressor, NitroBid, Detrol, and Synthyroid without an order since the resident's admission on 3/1/05. Refer to F 271 for information related to lack of admission orders. In addition, Temazepam is an hypnotic (sleeping medication), which, according to the 2005 PDR Nurse's Drug Handbook, is for short term use only. Review of the entire medical record showed no documentation from the physician that the benefits outweighed the risks of long term use. Review of the 3/14/04 pharmacy drug review revealed the pharmacist failed to report these irregularities to the physician or director of nursing. Interview with the consultant pharmacist on 4/7/05 at 1:25 PM revealed he was unaware of the need for a physician's statement related to the use of Temazepam. In addition, the pharmacist stated he did not always review the orders.	F 429	F 429 (Continued from previous page) No resident will be accepted for admission or re-admission from the hospital, home, or other facility until written orders are obtained and signed by the attending physician. 4/20/05 Care plan implemented for alterations in sleep patterns. Pharmacy and social services are in the process of developing support documentation for each resident prescribed with hypnotics. 5/23/05 Signed copy of order for res #16 are in the chart. Physician has addressed hypnotic for res #16. (JC) will be reviewed at quarterly QA. (JC)	
F 454	483.70 PHYSICAL ENVIRONMENT	F 454		

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F 464 SS=E	Continued From page 43 The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect the health and safety of the residents, staff and public by not providing a back flow valve in one of two shower rooms, and not assuring an air gap between the ice machine drainage pipe and the drain. The findings were: 1. Observation on 4/5/05 at 6:30 PM revealed the shower hose in the women's hall shower was not equipped with a back flow valve to prevent contaminated water from siphoning back into the system of the building. On 4/7/05 at 7:40 AM, the maintenance director stated the shower should have a back flow valve, but there was not one visible. 2. Observation on 4/6/05 at 9 AM revealed the ice machine did not have an air gap between the drainage pipe and the drain. On 4/7/05 at 7:40 AM, the maintenance director stated he was not aware there was not an air gap, but confirmed an air gap was needed.	F 464	This facility will be equipped and maintained to protect the health and safety of residents, personnel, and the public. This will be accomplished by: 1. A Back flow valve for the shower has been ordered and will be installed by the plumber as soon as it arrives. 2. Maintenance has corrected the issue of the air gap between the drainage pipe and the drain of the ice machine. Will be addressed at quarterly QA. (HC)	5/23/05 4/25/05
F 467 SS=D	483.70(h)(2) PHYSICAL ENVIROMENT The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by:	F 467	This facility will have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This will be accomplished by:	

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F 467	Continued From page 44 Based on observation and staff interview, the facility failed to have a fully functioning and operational mechanical ventilation system in two of two shower rooms. The findings were: 1. Observation of the women's shower room on 4/4/05 at 4:50 PM and on 4/5/05 at 8:30 PM revealed it was humid and smelled of mold. Observation of the ceiling exhaust vent revealed the vent was closed. On 4/5/05 at 9:10 AM, a light plastic bag was put up against the vent; there was no suction to grab the bag. During an interview on 4/7/05 at 8:46 AM, certified nurse aides (CNAs) #15 and #16 stated the shower room became hot and humid when bathing residents. 2. Observation of the men's shower room on 4/7/05 at 10:50 AM revealed the exhaust vent was closed. When a piece of tissue paper was held against the vent, there was no suction to grab the paper. 3. When asked about the exhaust vents in the shower rooms on 4/7/05 at 7:40 AM, the maintenance director stated he was not sure how to test the vents to see if they were working, because he was not familiar with the system. 4. Review of the facility's policy "Ventilation" (section V, unit A, Subject 3, undated) revealed "...all individual bath rooms...shall be ventilated adequately by use of a ventilator and exhaust fan equipment...all ventilation equipment shall be kept in good operating order and checked frequently by the maintenance supervisor."	F 467	F 467 (Continued from previous page) 1. The fan is attached to the heat lamp in the shower room. When the heat lamp is turned on the fan is activated. The fan was not running the day of inspection but has since been corrected. A cold air vent is installed next to the light which was closed because of causing a chill to a wet resident. 2. The exhaust vent was closed for comfort of the resident. A new heater and fan has been obtained and will be installed in the men's shower room. 3. The current maintenance man is a newly hired employee and had not familiarized himself with all the equipment in the building at that time. The plumber and electrician are assisting him with familiarization of the testing of the equipment. 4. The current ventilation system was installed in 1997. The large vents are in the east and west wings. All ventilation equipment will be checked by the maintenance supervisor. will be reviewed at quarterly QA. (PE)	5/23/05
F 495 SS=D	483.75(e)(4) ADMINISTRATION A facility must not use any individual who has	F 495	F 495 on next page	

JE 5/12/05

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F 495	Continued From page 45 worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in s483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure only nurse aides performed nurse aide tasks for two non-sample residents. Observation revealed an employee, who was not a nurse aide and was not in a nurse aide training program, feeding non-sample residents #34 and an unidentified resident. At the time of the survey, the State did not have an approved feeding assistance program. The findings were: Observation on 4/5/05 at 8:05 AM and 8:07 AM during the breakfast meal revealed the activities director seated next to resident #34 and an unidentified resident. The activities director gave each resident bites of food. During an interview on 4/5/06 at 9 AM, the activities director stated she fed residents during meals, but she was not a certified nurse aide (CNA), nor was she in a nurse aide training program. The activities director stated she received training on feeding residents from the staff development coordinator (SDC) a couple of years ago. Observation on 4/5/05 at 11:42 AM showed the activities director again feeding the unidentified resident during the lunch meal. During interviews on 4/7/06 at 8:06 AM and	F 495	F 495 (Continued from previous page) The activities director has been instructed that she will be allowed to serve trays but will not be allowed to assist with feeding residents until she has completed an approved Feeding Assistants course. will be reviewed at quarterly QA. (JE)	4/11/05

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F 495	Continued From page 46 9:20 AM, the administrator confirmed the activities director assisted residents with feeding, although she was not a nurse aide, or in a nurse aide training program. The administrator stated she couldn't find anything in the activity director's personnel file related to completion of a feeding assistance program.	F 495		
F 520 SS=D	483.75(o)(1) ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of signed attendance records, the facility failed to assure physician attendance at the quality assurance (QA) meetings during three of the last four meetings. The findings were: On 4/7/05 at 11:12 AM, interview with the administrator and review of the attendance records revealed the designated physician did not attend the QA meeting in January 2005 nor the meeting prior to that. The latter attendance record was undated, and the administrator was unable to accurately determine the date. In addition, the physician did not attend the QA meeting on 6/10/04. Furthermore, the facility failed to review the minutes from the two most recent meetings with the designated physician.	F 520	This facility will ensure physician attendance at the quality assurance meetings. This will be accomplished by: Concerning the June 10, 2004 meeting, the medical director was out of town and unable to attend the meeting. On January 12, 2006, a QA meeting took place. The Medical Director had been unable to attend the meeting and therefore the minutes were taken to his office. We met with him and discussed the protocol on oxygen use in the facility. On March 7, 2005 a QA meeting was held at his office, his input is in the minutes and they are signed. We are however seeking to replace our current medical director with someone who is more interested the elderly and also in completing the tasks of the Medical Director. will be reviewed at quarterly QA. (ME)	5/23/05