POC accepted 9/23/11 Cathy Cloutier

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	635021	A. BUILDING _____ B. WING _____	09/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- certified nursing assistant DON- director of nursing MDS- Minimum Data Set RN- registered nurse ROM- range of motion Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	**This Plan of Correction constitutes our Allegation of Compliance.** F278 The facility will ensure that Minimum Data Set (MDS) assessments are accurate. This will be accomplished by:	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	1a) Resident #9, #20 and #34's MDS data inaccuracies will be reviewed with the MDS coordinators and social services to ensure accuracy in the future. b) All other residents MDS data will be reviewed with the MDS coordinators and social services to ensure accuracy.	11/1/11 11/1/11

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

Anita Cox-Mills | BNHA * Facility Administrator * 9/16/11

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	880 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 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 ensure MDS assessments were accurate for 3 of 15 sample residents (#9, #20, #34). The findings were: 1. Medical record review showed resident #9 had diagnoses that included Alzheimer's Disease, dementia and manic depression. Review of the 7/30/11 annual MDS assessment section B showed s/he usually understood others and could make him/herself understood. However, sections C and D showed the interviews for mental status and mood could not be conducted due to the resident being rarely/never understood. In addition, section E showed the resident did not exhibit wandering behavior. However, review of the nurse's notes dated 7/24/11 at 1 AM, during the 7-day look back period, showed the resident was "wandering around in wheel chair." 2. Medical record review showed resident #20 had diagnoses that included dementia, arthritic knee pain, degenerative joint disease and osteoarthritis. Review of the 7/2/11 annual MDS assessment section B showed the resident made his/herself understood and had the ability to understand others. However, sections C and D for mental status and mood showed interviews could not be conducted due to the resident being rarely/never understood.	F 278	c) MDS coordinators and social services will be in serviced regarding accuracy of the MDS assessments and the mental status and mood interviews. d) Director of Nursing to audit monthly for compliance and report results quarterly to the Quality Improvement (QI) Committee for review and recommendations.	11/1/11 11/1/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/26/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 3. Medical record review for resident #34 had diagnoses that included dementia, and osteoporosis. Review of the 3/5/11 annual MDS assessment section B showed the resident made him/herself understood and usually understood others. However, sections C and D showed the interviews for mental status and mood could not be conducted due to the resident being rarely/never understood. 4. Interview with the social services director on 8/25/11 at 10:20 AM revealed he thought wandering only included leaving/exiting the facility and did not include entering other resident's rooms uninvited or other areas within the facility. According to September 2010, CMS RAI Version 3.0 Manual, "Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction.". 5. Interview with MDS coordinator #1 on 8/25/11 at 8:40 AM acknowledged the MDS assessments needed to be monitored more closely for accuracy. Further, she stated residents #9, #20, and #34 were not cognitively intact and did not understand and were not always understood.	~~F 278~~	F282 The facility will ensure that resident care is provided to residents in accordance with their care plans. This will be accomplished by: 1a) The Certified Nurse Aides responsible for providing care for residents #9, #13, #34 and #37 will be given one-to-one education regarding providing toileting and functional maintenance programs according to these resident's care plans.	11/1/11
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282	b) All nursing staff will be in serviced regarding providing care according to each resident's care plan. c) Director of Staff Development and Education to audit monthly for compliance and report results quarterly to the Quality Improvement (QI) Committee for review and recommendations. 11	11/1/11 11/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 by: Based on observation, medical record review, and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 4 of 13 sample residents (#9, #13, #34, #37). The findings were: 1. Review of the current care plan, dated 7/6/11, revealed staff were instructed to follow the toileting schedule for resident #37. According to the "Individualized bowel and bladder management program" dated 5/17/11, staff were instructed to take the resident to the toilet after breakfast, and again before lunch. Observation on 8/23/11 from 6:41 AM until 10:20 AM revealed the resident had not been taken to the toilet after breakfast. At 10:20 AM when CNA's #2 and #3 assisted the resident to the toilet before lunch, the resident's incontinence brief was visibly wet with urine. During an interview on 8/24/11 at 3 PM, the RN responsible for the bladder program stated the resident should have been toileted twice between breakfast and lunch. 2. Review of the care plan for resident #9 last dated 8/23/11 showed the resident was to participate in the restorative functional maintenance program (FMP). Review of the FMP flow sheet for July and August 2011 showed s/he was to receive lower extremity exercises three to five days a week. However, s/he received the therapy only one to two times each week. 3. Review of the care plan last dated 8/16/11 showed resident #13 was to participate in the restorative FMP. Review of the FMP flow sheets for June, July and August 2011 showed the resident was to receive range of motion and	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	880 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4 resistance exercises three times a week. However, s/he only received or was offered the exercises four of the ten weeks as scheduled. 4. Review of the care plan last dated 7/19/11 showed resident #34 was to participate in a restorative FMP per physician orders. Review of the FMP flow sheet for July and August 2011 showed s/he was to ambulate with two staff members four times a week. However, s/he received the therapy only one to three times each week. 5. Interview with the restorative nurse on 8/25/11 at 8:40 AM revealed staff assigned to the restorative program were sometimes pulled to provide resident care due to staff shortages. Therefore, the residents on the restorative care program didn't always receive the scheduled therapy.	~~F 282~~	F286 The facility will ensure that resident assessments completed within the previous 15 months will be accessible to all professional staff. This will be accomplished by: 1a) All professional staff will be given computer access to resident #1, #7, #6, #9, #13, #20 #22, #25, #34, #37, #40 and #47's assessments.	11/1/11
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 15 months of MDS assessments were kept in the active medical record, and were accessible to all professional staff for 12 of 13 sample residents (#1, #6, #7, #9, #13, #20, #22, #25, #34, #37, #40, #47). The findings were:	F 286	b) All professional staff will be given computer access to all resident assessments. c) All professional staff will be in serviced regarding how to access each resident's computer assessment. d) Medical Records staff to audit monthly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/1/11 11/1/11 11/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536021	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	800 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 5 Medical record review for the following residents revealed 15 months of MDS assessments were not in the active medical record: #1, #6, #7, #9, #13, #20, #22, #25, #34, #37, #40, #47. During an interview on 8/23/11 at 2 PM, MDS coordinator #1 stated only the signature pages were printed off and placed in the medical record. She stated the MDS assessments were in the computer. When asked if all staff had access to the MDS assessments in the computer, she replied "no". She stated the only staff that had access were medical records staff, the DON, the MDS coordinators, and the administrator.	~~F 286~~		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure restorative nursing care was provided as ordered by the physician for 1 of 1 sample resident (#37) who did not have ROM limitations, but was on a restorative program. The findings were: Review of physician orders showed on 6/7/11, the physician signed an order changing the functional maintenance program (FMP) for restorative nursing for resident #37. Review of the July and	F 309	F309 The facility will ensure that professional standards are followed related to physician orders. This will be accomplished by: 1a) Resident# 37 is now receiving restorative services as per physician order. b) Nursing staff will be in serviced on completing 24 hour chart checks to ensure that physician orders written are noted and implemented. c) Medical Records staff to audit monthly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/1/11 11/1/11 11/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 August 2011 restorative documentation, however, revealed the changes to the restorative program were never implemented. On 8/24/11 at 3 PM, the restorative nurse looked at the order, and stated nursing staff never noted the order. Therefore, the order was never carried out. Reference: According to the Wyoming State Board of Nursing Rules and Regulations, Chapter 3 Standards of Nursing Practice, nurses must practice according to the orders of a physician, dentist, or midlevel practitioner.	~~F 309~~	F311 The facility will ensure that restorative services are provided to residents in order to maintain or improve their current level of functioning for activities of daily living. This will be accomplished by:	
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure restorative services were provided to maintain or improve the current level of function for activities of daily living (ADLs) for 3 of 5 sample residents (#9, #13, #34) who received restorative services. The findings were: 1. Review of the medical record for resident #9 revealed s/he had diagnoses that included Alzheimer's disease. Review of the care plan last dated 8/23/11 showed the resident was to participate in the restorative functional maintenance program (FMP) for ADLs, and falls. Review of the FMP flow sheet for July and August 2011 showed s/he was to receive lower extremity	F 311	1a) Restorative aides will be educated regarding providing restorative services for residents #9, #13 and #34 according to their plans of care and pertinent documentation. b) All nursing staff will be in serviced regarding providing restorative services for residents according to their plans of care and pertinent documentation. c) Director of Staff Development and Education to audit monthly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/1/11 11/1/11 11/1/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 7 exercises three to five days a week. However, s/he received the therapy only one to two times each week. 2. Review of the medical record for resident #13 showed s/he had diagnoses that included right side cerebrovascular accident, and osteoporosis. Review of the care plan last dated 8/16/11 revealed the resident was to participate in the FMP for alteration in ADLs and mobility. Review of the FMP flow sheets for June, July and August 2011 showed the resident was to receive range of motion and resistance exercises three times a week, however, s/he only received or was offered the exercises four of the ten weeks as scheduled. 3. Review of the medical record for resident #34 revealed diagnoses that included osteoporosis, subdural hematoma, Parkinson's and dementia. Review of the care plan last dated 7/19/11 showed the resident was to participate in FMP per orders for ADLs, pain and mobility. Review of the FMP flow sheet for July and August 2011 showed s/he was to ambulate with two staff members four times a week. However, s/he received the therapy only one to three times each week. 4. Interview with the restorative nurse on 8/26/11 at 8:40 AM revealed staff assigned to the restorative program were sometimes pulled to provide resident care due to staff shortages. Therefore, the residents on the restorative care program didn't always receive the scheduled therapy.	~~F 311~~	F315 The facility will ensure that residents who are incontinent of bladder receive appropriate services to restore as much normal bladder function as possible. This will be accomplished by: 1a) Certified nurse aides who failed to toilet resident #37 according to his/her toileting plan will be given one-to-one education regarding providing appropriate services to restore as much normal bladder function as possible for this resident, thus following the individualized toileting plan.	11-1-11
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 8 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to promote continence and keep the resident as dry as possible for 1 of 5 sample residents (#37) who were incontinent of bladder. The findings were: Review of the current care plan, dated 7/6/11, revealed staff were instructed to follow the toileting schedule for resident #37. According to the "Individualized bowel and bladder management program" dated 5/17/11, staff were instructed to take the resident to the toilet after breakfast, and again before lunch. The following concerns were identified: a. Observation of the resident on 8/23/11 at 6:41 AM revealed the resident was in the dining room for breakfast. At 7:35 AM, CNA #1 took the resident to his/her bathroom to perform oral care, but did not take the resident to the toilet. At 8:20 AM CNAs #2 and #3 used the mechanical lift to transfer the resident from the wheelchair to the recliner. The resident was not offered the toilet. At 10:20 AM (3 hours 39 minutes from start of	F 315	F315 b) All nursing staff will be in serviced regarding ensuring that residents who are incontinent of bladder receive appropriate services to restore as much normal bladder function as possible, thus following Individualized tolleting plans. c) Director of Staff Development and Education to audit monthly for compliance and report results quarterly to the Quality Improvement Committee for review and recommendations.	11/1/11 11/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	880 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 9 observation at breakfast), CNAs #2 and #3 went to the resident's room to get the resident ready for lunch. CNA #2 told the resident they were going to take him/her to the toilet. The resident replied "Should have done that this morning." The resident was transferred to the toilet using a mechanical lift, and his/her incontinence brief was visibly wet with urine. b. During an interview on 8/24/11 at 3 PM, the RN responsible for the bladder program stated the resident should have been toileted twice between breakfast and lunch. She stated "after breakfast" means that when staff are done assisting in the dining room, they should start taking residents to the bathroom.	~~F 315~~		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the manufacturer's manual, the facility failed to ensure sit-to-stand lifts were used in a safe manner for 2 of 3 residents (#34, #44) observed using the lift. The findings were: 1. Review of the Operator and Maintenance Manual for Patient Slings stated: "Standing	F 323	**F323** **The facility will ensure that each resident receives appropriate supervision and assistance devices to prevent accidents. This will be accomplished by:** **1a) Residents # 34 and #44 will be assessed for use of a more appropriate mechanical lift to meet their needs.** **b) Certified nurse aides responsible for using the mechanical sit-to-stand lift for residents #34 and #44 will receive one-to-one education regarding appropriate use of the device.**	**11/1/11** **11/1/11**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 Slings- Individuals that use the standing sling MUST be able to support the majority of their own weight, otherwise injury can occur." The following concerns were identified: a. Medical record review for resident #34 showed s/he had diagnoses that included osteoporosis, Parkinson's disease and dementia. Observation on 8/23/11 at 9:35 AM showed CNA #4 transferred the resident using the sit-to-stand lift to the toilet. The resident had his/her knees bent and was not holding onto the lift with his/her hands. The resident was using the sling under his/her arms for support. b. Medical record review for resident #44 showed s/he had diagnoses that included osteoarthritis, degenerative joint disease and Alzheimer's disease. Review of his/her care plan showed the staff was to use a mechanical lift for transfers with extensive assist. Observation on 8/23/11 at 12:50 PM showed the resident was transported from his/her room to a lounge chair in the sitting area with the use of a sit-to-stand lift. The resident was observed straining against the cushioned sling under his/her arms, and not holding onto the hand bars for support. The resident was grimacing during transfer. 2. Interview with MDS coordinator #1 on 8/25/11 at 8:40 AM stated the lifts needed to be reassessed for residents #34 and #44. Further, she stated staff members were to inform her if they determined a resident needed a lift for transfers, or a change in the type of lift needed.	F 323	c) All nursing staff will be in serviced regarding the appropriate use of all lifts, including sit-to-stand lifts for all residents who require their use. d) Unit managers will evaluate residents requiring the use of a mechanical lift monthly and/or immediately if there is a resident change in status to ensure the appropriate device is used. e) Director of Staff Development and Education to audit monthly for compliance and report results quarterly through QI process for review and recommendation.	11/1/11 11/1/11 11/1/11
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	880 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 11 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews, observation, and review of facility procedures, the facility failed to ensure the proper treatment and care of 1 of 1 (#7) sample residents with a tracheostomy. The findings were: Interview on 8/23/11 at 7:40 AM with RN #1 revealed resident #7 performed his/her own tracheostomy care. She stated she had observed the resident doing the care and there were no problems. Interview on 8/23/11 at 9 AM with the resident confirmed s/he did the tracheostomy care her/himself twice a day, and also suctioned him/herself as needed. The following concerns were identified during an observation of the resident performing tracheostomy care and suctioning on 8/23/11 at 9:30 AM: a. The resident shared a bathroom with another resident. The resident's suction machine was sitting on the floor in the bathroom with the suction catheter wrapped around the sink. b. Without washing his/her hands or putting on gloves, the resident removed the plastic cannula from the tracheostomy site and placed it in a container of hydrogen peroxide and sterile	F 328	F328 The facility will ensure that a resident with a tracheostomy receives proper treatment and care. This will be accomplished by: 1a) Resident #7 was seen by a physician and suctioning was discontinued. b) Resident #7 was given one-to-one education regarding appropriate infection control practices in the care of the tracheostomy. The resident signed an informed refusal of care acknowledging the risks of not following appropriate infection control practices.	9/13/11 9/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 12 water to soak. c. The resident used a toothette (a sponge tip applicator) soaked in hydrogen peroxide to clean the skin around the outside of the tracheostomy opening. d. The resident then turned on the suction machine, picked up the suction catheter that was wrapped around the sink, suctioned the moisture up on the skin around the tracheostomy opening and then proceeded to insert the catheter 1-2 inches into the tracheostomy opening to suction out secretions. e. When the suctioning was completed, with his/her bare hands that had not been washed, the resident took the plastic cannula out of the soaking solution, rinsed it off with tap water and reinserted it in the tracheostomy opening. The facility's policy on suctioning a tracheostomy tube included, "1.b. Use sterile equipment to avoid widespread pulmonary and systemic infection (Note: Suctioning of the lower airway is a sterile procedure. All equipment that comes in contact with the lower airway must be sterile." Review of the facility's procedure for tracheostomy care revealed hand washing should be performed and gloves should be worn during the procedure. Interview on 8/25/11 at 8 AM with the administrator revealed there was no documentation the staff completed any education or did any monitoring of the resident while s/he performed tracheostomy care and suctioning.	F 328	c) All nursing staff will be in serviced regarding appropriate infection control practices in the care of a tracheostomy. d) Director of Staff Development and Education to audit monthly for compliance and report results quarterly through QI process for review and recommendation. F441 The facility will ensure that a resident with a tracheostomy (trach) receives education and monitoring of infection control techniques for self care and that follow-up cultures are completed if required. This will be accomplished by:	11/1/11 11/1/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	1a) Culture results for resident #7's trach site showed colonized MRSE. Per physician order and facility policy, one culture was required. Trach suctioning was discontinued by physician. b) Resident #7 was given one-to-one education regarding appropriate infection control practices in the care of the trach. The resident signed an informed refusal of care acknowledging the risks of not following appropriate infection control practices. c) All nursing staff will be in serviced regarding appropriate infection control practices in the care of a tracheostomy. d) Director of Staff Development and Education to audit monthly for compliance and report results quarterly through QI process for review and recommendation.	9/13/11 9/13/11 11/1/11 11/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536021	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 Based on observation, review of policies and procedures, staff and resident interviews, and medical record review, the facility failed to ensure 1 of 1 (#7) sample residents with a tracheostomy received education and monitoring of infection control techniques for self care of the tracheostomy. In addition, the facility failed to ensure follow up for a post operative infection was completed for 1 of 1 (#7) sample residents who had an infection at the surgical site of a tracheostomy. The findings were: 1. Medical record review revealed resident #7 was admitted to the facility on 6/2/11 and an infection control note dated 6/6/11 showed the resident had a history of throat cancer and recently had a post operative methicillin-resistant Staphylococcus aureus (MRSA) infection. The infection control nurse further stated the resident needed three negative cultures in order to discontinue respiratory/contact isolation. A physician progress note dated 6/9/11 revealed the resident was recently treated for a tracheostomy site infection. A nurse's note dated 6/8/11 revealed the resident had completed the antibiotic therapy. Further medical record review showed no follow-up culture results from the tracheostomy site. Interview on 8/25/11 at 8 AM with the administrator confirmed the infection control nurse should have done the follow-up cultures, but did not obtain them. 2. Interview on 8/23/11 at 7:40 AM with RN #1 revealed resident #7 performed his/her own tracheostomy care. She stated she had observed the resident doing the care and there were no problems. Interview on 8/23/11 at 9 AM with the resident confirmed s/he did the tracheostomy	F 441		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 care her/himself twice a day, and also suctioned him/herself as needed. The following concerns were identified during an observation of the resident performing tracheostomy care and suctioning on 8/23/11 at 9:30 AM: a. The resident shared a bathroom with another resident. The resident's suction machine was sitting on the floor in the bathroom with the suction catheter wrapped around the sink. b. Without washing his/her hands or putting on gloves, the resident removed the plastic cannula from the tracheostomy site and placed it in a container of hydrogen peroxide and sterile water to soak. c. The resident used a toothette (a sponge tip applicator) soaked in hydrogen peroxide to clean the skin around the outside of the tracheostomy opening. d. The resident then turned on the suction machine, picked up the suction catheter that was wrapped around the sink, suctioned the moisture up on the skin around the tracheostomy opening and then proceeded to insert the catheter 1-2 inches into the tracheostomy opening to suction out secretions. e. When the suctioning was completed, with his/her bare hands that had not been washed, the resident took the plastic cannula out of the soaking solution, rinsed it off with tap water and reinserted it in the tracheostomy opening. The facility's policy on suctioning a tracheostomy tube included, "1.b. Use sterile equipment to avoid widespread pulmonary and systemic infection (Note: Suctioning of the lower airway is a sterile procedure. All equipment that comes in contact with the lower airway must be sterile." Review of the facility's procedure for	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	980 US HWY 20 SOUTH BASIN, WY 82410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 tracheostomy care revealed hand washing should be performed and gloves should be worn during the procedure. Interview on 8/25/11 at 8 AM with the administrator revealed there was a facility tracheostomy surveillance sheet that was to be completed by staff when they performed tracheostomy care or when they educated the resident to do self-care. She confirmed there was no documentation the staff completed any education or did any monitoring of the resident while s/he performed tracheostomy care and suctioning.	F 441		
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medical records were secure from unauthorized access in 3 of 3 rooms where the records were stored. The findings	F 516	F516 The facility will ensure clinical record information is safeguarded against unauthorized use. This will be accomplished by: A) Locks to the medical records room and the health information room have been changed. The medical records in the basement computer room have been moved to another room in the basement and the lock has been changed. Only medical records personnel have a key to enter these rooms. b) A policy and procedure will be written to address unauthorized personnel needing to enter an area where clinical record information is safeguarded.	9/13/11 11/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	08/25/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 516	Continued From page 17 were: Observation on 8/25/11 at 9:30 AM revealed medical records were stored in the medical records room, the health information room, and the main computer room in the basement of the facility. The doors to these rooms were locked, but the records were kept on open shelves, desks, and boxes. During the observation, the maintance director opened the locked doors with a key. Interview at that time with the maintance director confirmed the medical records were not stored in locked cabinets and he had a key to all three rooms.	F 516	c) All staff will be in serviced regarding the policy and procedure for unauthorized personnel needing to enter an area where clinical record information is safeguarded. d) Medical records manager to audit monthly for compliance and report results quarterly through the Quality Improvement process for review and recommendation.	11/1/11 11/1/11